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92-421

No. _____

Supreme Court, U.S.
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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1992

RICHMOND MEMORIAL HOSPITAL,

Petitioner,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

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QUESTIONS PRESENTED

1. Whether a cause of action upon which relief may be granted exists under the federal patient-dumping statute, 42 U.S.C. § 1395dd, for the transfer of an expectant mother from one hospital to another where she did not present to the emergency room of the hospital, she was admitted to the hospital and treated for five days as an inpatient, she was initially stabilized, and she was transferred to a hospital with a neonatal intensive care unit some twenty minutes away because her condition had begun to deteriorate?

2. Whether the federal patient-dumping statute, 42 U.S.C. § 1395dd, preempts notice of claim and malpractice review panel provisions under state law?

LIST OF PARTIES

The parties to the proceeding below were petitioner Richmond Memorial Hospital, which was the defendant - appellee, and respondents Taja Smith and Connie Smith, who were the plaintiffs - appellants.

RULE 29.1 LIST

The petitioner Richmond Memorial Hospital, a non-profit corporation organized under the laws of the Commonwealth of Virginia, is owned by Health Corporation of Virginia. Richmond Memorial Hospital does not own any subsidiaries.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

LIST OF PARTIES ii

RULE 29.1 LIST ii

OPINIONS BELOW 2

JURISDICTION 2

STATUTES INVOLVED 3

STATEMENT OF THE CASE 4

REASONS FOR GRANTING THE WRIT 18

I. THE FEDERAL PATIENT DUMPING STATUTE DOES NOT APPLY TO THE TRANSFER OF AN INPATIENT WHO DID NOT PRESENT TO THE HOSPITAL'S EMERGENCY DEPARTMENT AND WHO WAS ADMITTED, STABILIZED AND TREATED FOR FIVE DAYS PRIOR TO HER TRANSFER TO ANOTHER HOSPITAL BASED ON MEDICAL NECESSITY . . . 21

II. THE NOTICE OF CLAIM AND PANEL REQUIREMENTS OF VIRGINIA'S MEDICAL MALPRACTICE ACT ARE NOT PREEMPTED BECAUSE THEY DO NOT DIRECTLY CONFLICT WITH ANY REQUIREMENT OF COBRA 49

CONCLUSION 54

APPENDIX

Opinion and Judgment of Supreme Court of Virginia . . A-1

Letter Opinion of Circuit Court of City of Richmond B-1

Order of Circuit Court Court of City of Richmond B-20

Supreme Court of Virginia Order Denying Petition for Rehearing C-1

42 U.S.C. § 1395dd (1988) . . . D-1

Va. Code Ann. § 8.01 - 581.2 (Repl. Vol. 1992) . . D-16

Department of Health and Human Services, Health Care Financing Administration, Statement on Enforcement of the Anti-Dumping Provisions

of Section 1867 of the Social Security Act (Jan. 1992) E-1

American Hospital Association, Medicare Requirements for Emergency Services and Transfers (Oct. 1990) F-1

American Hospital Association Letter to Ms. Wilensky, Administrator, Health Care Financing Administration (July 9, 1990) G-1

Letter from Ms. Wilensky, Administrator, Health Care Financing Administration to Mr. Rettig (Sept. 17, 1990) . H-1

Department of Health and Human Services Letter to Mr.Hodges (Aug. 14, 1990) I-1

TABLE OF AUTHORITIES

Page No.

Cases:

Arlington Yellow Cab Co. v. Transportation, Inc., 207 Va. 313, 149 S.E.2d 877 (1966) 7

Bowman v. State Bank of Keysville, 229 Va. 534, 331 S.E.2d 797 (1985) 7

Bryant v. Riddle Memorial Hospital, 689 F. Supp. 490 (E.D. Pa. 1988) 4

Burrows v. Turner Memorial Hospital, Inc., 762 F. Supp. 840 (W.D. Ark. 1991) 52

Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984) 48

Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 (1975) 13, 14, 15, 16

Crandon v. United States, 494 U.S. 152 (1990) 40

Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990) 24

Draper v. Chiapuzio, 755 F. Supp. 331 (D. Or. 1991) . . . 52

Erlenbaugh v. United States, 409 U.S. 239 (1972) 40

Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989) 28

Glisson v. Loxley, 235 Va. 62, 366 S.E.2d 68 (1988) 50

Goodyear Atomic Corp. v. Miller, 486 U.S. 174 (1988) 14, 15

HCA Health Services of Indiana, Inc. v. Gregory, 596 N.E.2d 974 (Ind. App. July 30, 1992) 20

Helton v. Phelps County Regional Medical Center, 1992 WL 174298 (E.D. Mo. July 24, 1992) 20

Johnson v. University of Chicago Hosp., 774 F. Supp. 510 (N.D. Ill. 1991) 24

Lyons v. Grether, 218 Va. 630, 239 S.E.2d 103 (1977) 46

Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. 1269 (E.D. Tex. 1990) 24

Petrovics v. Prince William Hosp. Corp., 764 F. Supp. 415 (E.D. Va. 1991) 28

Sorrells v. Babcock, 733 F. Supp. 1189 (N.D. Ill. 1990) 4

Southland Corp. v. Keating, 465 U.S. 1 (1984) 15, 16

Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990) 28

Stuart Circle Hospital v. Curry, 173 Va. 136, 3 S.E.2d 153 (1939) 47

Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990) 4, 25, 28

Wilson v. Atlanticare Medical Center, 868 F.2d 34 (1st Cir. 1989) 52

Statutes and Legislative Materials:

28 U.S.C. § 1257 . . 2, 12, 14, 16

42 U.S.C. § 1395dd (1988) . . . . . *passim*

Va. Code Ann. § 8.01-581.1 (Repl. Vol. 1992) 50

Va. Code Ann. § 8.01-581.2 (Repl. Vol. 1992) . . . 6, 12, 50

Va. Code Ann. § 8.01-581.9 (Repl Vol. 1992) 12, 51

H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. *reprinted in* 1986 U.S. Code Cong. & Admin. News 579 . . . . . 41, 44

H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. *reprinted in* 1986 U.S. Code Cong. & Admin. News 726 . . . . 41, 43

131 Cong. Rec. S13903 (Oct. 23, 1985) 42

131 Cong. Rec. S13904 (Oct. 23, 1985) 42, 45

Other Authorities:

C. Koch, Administrative Law & Practice § 3.53 (1985) 48

Frew Consulting Group, Ltd., "HCFA Issues COBRA Enforcement Policies," *Critical Information Resource* (March 1992) 33

2 J. Moore, J. Lucas, H. Fink & C. Thompson, Moore's Federal Practice ¶ 3.09[2] n.15 (2d ed. 1991) 53

IN THE SUPREME COURT
OF THE UNITED STATES

OCTOBER TERM, 1992

RICHMOND MEMORIAL HOSPITAL,

Petitioner,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother Connie Elizabeth Smith, and CONNIE ELIZADETH SMITH, individually,

Respondents.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

The petitioner Richmond Memorial Hospital respectfully prays that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of Virginia, entered in the above-entitled proceeding on April 17, 1992.

OPINIONS BELOW

The opinion of the Supreme Court of Virginia is reported at 243 Va. 445, 416 S.E.2d 689 (1992) and is reprinted in the Appendix hereto at A-1.

The letter opinion of the Circuit Court of the City of Richmond (Harris, J.) is not reported. It is reprinted in the Appendix hereto at B-1.

JURISDICTION

The date of the entry of judgment sought to be reviewed in this case is April 17, 1992. On June 5, 1992, the Supreme Court of Virginia denied Richmond Memorial Hospital's timely petition for a rehearing.

The jurisdiction of this Court to review the judgment of the Supreme Court of Virginia is invoked under 28 U.S.C. § 1257(a).

STATUTES INVOLVED

The statutes at issue in this case are 42 U.S.C. § 1395dd (1988) and Va. Code Ann. § 8.01-581.2 (Repl. Vol. 1992) which are set forth verbatim at D-1 and D-16, respectively, in Appendix D attached hereto.

STATEMENT OF THE CASE

The plaintiffs-respondents, Taja Smith, an infant suing by and through her next friend and mother Connie Smith, and Connie Smith, individually, brought this action on July 17, 1990 in the Circuit Court of the City of Richmond alleging a violation of the Emergency Medical Treatment and Women in Active Labor provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. § 1395dd (the "Act"),[1] commonly referred to as the "patient dumping" or "anti-dumping" statute. The motion for judgment contained no other counts.

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[1] The courts have held that state and federal courts have concurrent jurisdiction over COBRA patient dumping claims. See, e.g., Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1133 (6th Cir. 1990); Sorrells v. Babcock, 733 F. Supp. 1189, 1192 (N.D. Ill. 1990); Bryant v. Riddle Memorial Hosp. 689 F. Supp. 490, 493 (E.D. Pa. 1988).

The patient dumping statute creates a private cause of action where an individual who has an emergency medical condition or is in active labor presents at a hospital emergency department and is refused a medical screening or is discharged or transferred without stabilizing treatment. § 1395dd(a). Transfers made in the best interest of the patient do not violate the statute. § 1395dd(c). No private remedy exists under the patient dumping statute for the transfer of a patient by the hospital unless such transfer directly results in personal harm to the plaintiff. § 1395dd(d)(3)(A).

On August 21, 1990, defendant-petitioner Richmond Memorial Hospital (the "Hospital") filed a demurrer on the grounds that the motion for judgment failed to state a cause of action under the Act, that

the plaintiffs failed to allege that indigency was the motivating reason for Connie Smith's transfer to another hospital, and that plaintiffs failed to give notice of their claims to the Hospital as required by § 8.01-581.2 of the Virginia Medical Malpractice Act.

On October 9, 1990 a hearing was held on the demurrer. On March 8, 1991, the trial court sustained the demurrer on the ground that while the facts alleged may have stated a common law cause of action for medical malpractice, they failed to state a cause of action for patient dumping under 42 U.S.C. § 1395dd. App. B 15, 18-20. The trial court held that the notice of claim provision of the Virginia Medical Malpractice Act was preempted by the federal Act. App. B 14-15.

The following facts were pleaded in plaintiffs' motion for judgment.[2] On July 18, 1988, plaintiff Connie Smith was admitted to Richmond Memorial Hospital as an inpatient with premature rupture of the membranes. Motion for Judgment, ¶¶ 1 and 2. On that same date it was determined by sonogram that the gestational age of the unborn child was approximately 33 weeks. Id. ¶¶ 3 and 4. Connie Smith received treatment at the Hospital for five days from July 18 to July 23. Id. ¶¶ 18 and 19. The Hospital did not refuse Connie Smith treatment, but rather treated and

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[2] Under Virginia law, the facts alleged in the motion for judgment are admitted for purposes of the Hospital's demurrer, Bowman v. State Bank of Keysville, 229 Va. 534, 536, 331 S.E.2d 797, 798 (1985), but allegations which represent legal conclusions are not admitted, Arlington Yellow Cab Co. v. Transportation, Inc., 207 Va. 313, 318-19, 149 S.E.2d 877, 881 (1966).

stabilized her. Transcript of Demurrer Hearing at 44.

During the afternoon and evening of July 22, Connie Smith's condition began to worsen. Motion for Judgment, ¶¶ 6 - 11. The leakage from her vagina turned from greenish yellow to dark green, and she complained of abdominal cramping. Id. ¶¶ 6 and 10. At midnight she was one centimeter dilated. Id. ¶ 11.

Personnel at Richmond Memorial Hospital consulted with Dr. Jones, Mrs. Smith's on-call obstetrician, by telephone at 10:00 p.m. on July 22 and at 1:00 a.m. on July 23 regarding her condition. Id. ¶ 21. Dr. Jones gave the order for Connie Smith's transfer to the Medical College of Virginia Hospital ("MCV"). Id. ¶ 22. Richmond Memorial Hospital does not have a Neonatal Intensive Care Unit and did not

have the facilities to care for a premature infant such as Taja Smith under the circumstances of this case. Id. ¶ 5.

At 2:10 a.m. on July 23, Connie Smith left the Hospital by ambulance and was transported to MCV. Id. ¶ 19. She was admitted to MCV at approximately 2:30 a.m. Id. ¶ 23. Shortly after admission to MCV she remained dilated one centimeter. Id. ¶ 30. Taja Smith was delivered by Cesarean operation at MCV at approximately 9:48 a.m. on July 23, 1988, more than seven-hours after her arrival there. Id. ¶ 42.

Both at birth and thereafter, Taja Smith experienced multiple health problems. Id. ¶¶ 45-60. Taja Smith remains permanently impaired as a result of birth-related injuries. Id. ¶ 60. Connie Smith also suffered physical injuries in connection with the birth of her child.

Id. ¶ 70. At all times pertinent hereto, Connie Smith was covered by health insurance. Transcript of Demurrer Hearing at 44.

Respondents appealed from the trial court's ruling sustaining the Hospital's demurrer, and the Hospital assigned cross-error to the trial court's ruling that the Virginia notice of claim provisions which pertain to suits against health care providers are preempted by COBRA. App. A 1, 7-8. The Supreme Court of Virginia held that a claim may be stated under COBRA despite the fact that the plaintiff did not present to the emergency room of the Hospital, was stabilized by the Hospital, and received treatment as a patient in the Hospital for five days prior to being transferred to a hospital with a neonatal intensive care unit. The court held that

subsection (c) of the Act dealing with the appropriateness of the transfer of a patient applies to all hospital patients without regard to the limitations imposed by Congress in subsection (a) which make the statute applicable to individuals presenting to the emergency department of a hospital who are determined to be in an emergency medical condition or in active labor. App. A, 17-18.

The court also ruled that the notice of claim provisions of the Virginia Medical Malpractice Act are preempted by the federal COBRA statute because they conflict with the two year statute of limitations prescribed for COBRA actions by 42 U.S.C. § 1395dd(d)(3)(C). App. A, 30-34. Under the notice of claim provisions, a plaintiff may not file suit until 90 days after written notification is provided to the

health care provider and, if the provider requests review by a malpractice review panel, until the panel completes its review. Va. Code Ann. § 8.01-581.2(A). Although § 8.01-581.9 of the Medical Malpractice Act tolls the "applicable statute of limitations" for a period of 120 days from the date notice is given or 60 days following the issuance of any opinion by the medical review panel, the Supreme Court of Virginia, relying upon a federal district court decision, held that these tolling provisions can not toll the statute of limitations prescribed by COBRA which creates a federal right of action. App. A, 33-34.

The court remanded the case for further proceedings. App. A-35. While 28 U.S.C. § 1257 (a), upon which jurisdiction is premised in this case, refers to

"[f]inal judgments or decrees rendered by the highest court of a State," this Court has in the past adopted a pragmatic approach to ascribing finality and reviewability to various situations where further lower court proceedings are contemplated but a federal issue has been finally determined and important federal concerns are at stake.

In Cox Broadcasting Corp. v. Cohn, the Court recognized four exceptions to the general finality rule. 420 U.S. 469, 477-78 (1975). Cases in the fourth category include situaticns where although a federal issue has been finally decided by the state court, there are further proceedings pending in which the party seeking review might prevail on the merits on nonfederal grounds, rendering review of the federal issue by the Court unnecessary, and where

reversal of the state court on the federal issue would end further litigation on the relevant cause of action. In such circumstances, where a refusal immediately to review the state court decision could seriously erode federal policy, this Court has entertained the federal issue. Id. at 482-83.

Applying the fourth exception in Cox Broadcasting, the Court has found finality in cases where further proceedings are contemplated. Following its "pragmatic approach," the Court found that the Ohio Supreme Court's holding that the Atomic Energy Act of 1954 did not preempt Ohio from applying workers' compensation safety requirements to accidents at nuclear facilities was a final judgment under 28 U.S.C. § 1257. Goodyear Atomic Corp. v. Miller, 486 U.S. 174, 180 (1988). In

Goodyear, the Court concluded that the unreviewed decision of the state supreme court would seriously erode federal policy in the area of nuclear power regulation and influence the regulation of federally owned nuclear power plants in states other than Ohio.

The Court also found the California Supreme Court's decision in Southland Corp. v. Keating, 465 U.S. 1 (1984) to be final within the meaning of the fourth exception in Cox Broadcasting. The state supreme court had held that claims under the California Franchise Investment Law were not arbitrable, and that the Federal Arbitration Act did not preempt the state statute. Id. at 6. This Court stated that if the California decision were to remain in effect, it would nullify contracts to arbitrate and seriously erode the federal

policy promoting arbitration of disputes. Id. at 7.

The instant case is reviewable under 28 U.S.C. § 1257 as a final decision of a federal issue because it is similar to those cases found to fit within the fourth category in Cox Broadcasting. First, without immediate review of the Virginia Supreme Court's decision, the Court may not have a future opportunity to pass on the federal issue in dispute. On remand, the Hospital may prevail on nonfederal grounds. The COBRA statute provides inter alia that an individual who suffers harm as the direct result of a participating hospital's violation of its requirements may obtain "those damages available for personal injury under the law of the State in which the hospital is located," § 1395dd(d)(3)(A), and that State or local law

requirements for suit are not preempted unless the requirement directly conflicts with the COBRA requirements, § 1395dd(f). Second, reversal of the Virginia Supreme Court's decision would terminate the litigation.

Finally, without review, the Virginia Supreme Court's interpretation of 42 U.S.C. § 1395dd would remain in effect and would seriously erode federal policy by extending the requirements of the Act beyond its language and its purpose, which is to ensure treatment of individuals who present to hospital emergency departments. All of the hospitals in the Commonwealth of Virginia would be subject to suit for claims which are not addressed by the COBRA statute and which constitute nothing more than traditional medical malpractice claims. It is not, and never has been, a

federal policy to usurp state regulation of medical malpractice law. This holding if left unreviewed will impinge upon important issues of federal-state comity.

REASONS FOR GRANTING THE WRIT

A writ of certiorari should be granted in this case because the Supreme Court of Virginia has wrongly decided an important question of federal law involving the reach of the federal patient dumping statute, 42 U.S.C. § 1395dd, which has not been, but ought to be, settled by this Court. The Virginia court held that the subsections of § 1395dd do not have to be read in light of one another and that this refusal to treat statute has application to any inpatient transferred by a hospital regardless of whether that individual ever presented to the emergency room of a Medicare

participating hospital or whether the hospital did in fact admit, treat and stabilize the patient. This opinion conflicts with the literal language of the Act, the clearly expressed intent of Congress, accepted principles of statutory construction, the interpretation of the federal agency charged with enforcing the statute, and, in principle, with the decisions of numerous courts holding that the COBRA statute does not extend to claims alleging misdiagnosis or inadequate treatment, which are essentially traditional medical malpractice claims.

As a result hospitals in Virginia are subject to suit for claims allegedly based on COBRA which are not in fact covered by the COBRA statute. In addition, the Virginia Supreme Court's decision deprives these hospitals of safeguards, such as

notice of claim and medical review panel provisions, enacted by the state legislature in order to protect health care providers from meritless suits and to contain the skyrocketing cost of malpractice insurance. Finally, courts outside of Virginia, some of which have already cited the Smith decision approvingly,[3] may also misinterpret the reach of the federal patient dumping statute based on the Virginia Supreme Court's rationale.

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[3] See, e.g., HCA Health Services of Indiana, Inc. v. Gregory, 596 N.E.2d 974 (Ind. App. July 30, 1992); Helton v. Phelps County Regional Medical Center, 1992 WL 174298, *4 (E.D. Mo. July 24, 1992).

I. THE FEDERAL PATIENT DUMPING STATUTE DOES NOT APPLY TO THE TRANSFER OF AN INPATIENT WHO DID NOT PRESENT TO THE HOSPITAL'S EMERGENCY DEPARTMENT AND WHO WAS ADMITTED, STABILIZED AND TREATED FOR FIVE DAYS PRIOR TO HER TRANSFER TO ANOTHER HOSPITAL BASED ON MEDICAL NECESSITY.

As both the trial court and the Supreme Court of Virginia recognized, the legislative history of the patient dumping statute indicates that it was passed to eliminate the practice of some hospitals of refusing to treat persons in emergency conditions for economic reasons. App. B 15-16; App. A 8-10. In the instant case, plaintiff Connie Smith did not allege that she was refused treatment by Richmond Memorial Hospital or that she was transferred to MCV because she was uninsured or unable to pay hospital charges. In fact, plaintiffs' counsel conceded at the demurrer hearing that

Connie Smith was covered by health insurance when she was hospitalized at Richmond Memorial. Transcript of Demurrer Hearing at 44.

The patient dumping statute, 42 U.S.C. § 1395dd, requires that all Medicare participating hospitals with emergency departments provide an appropriate medical screening examination within the capability of the emergency department to any person who presents himself at the emergency room, regardless of ability to pay, in order to determine whether or not an emergency medical condition exists or to determine if the person is in active labor. § 1395dd(a). If it is determined that the person has an emergency medical condition or is in active labor, the hospital may not discharge or transfer the patient without providing stabilizing treatment within its

capabilities or without determining that a transfer would be in compliance with the requirements of the statute. § 1395dd(b). Such a patient may be transferred if a determination is made that "the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer." § 1395dd(c)(1)(A)(ii). An individual who suffers personal harm as a direct result of a violation of a requirement of the patient dumping statute may obtain such damages as are allowed under state law. § 1395dd(d)(3)(A).

In order for subsections (b) and (c) of the Act to apply, a patient must present to the emergency room of a hospital in an emergency medical condition or in active

labor. As the court stated in Owens v. Nacogdoches County Hospital District, 741 F. Supp. 1269, 1271-72 (E.D. Tex. 1990):

> The Act was a response to a national epidemic of "dumping," the practice by hospitals of refusing emergency care to indigent patients outright or of transferring such patients, without regard to the necessity for stabilizing their condition, to other-- typically public-- hospitals....To address these problems, 42 U.S.C. § 1395dd requires that any hospital with an emergency room must provide a medical screening examination to any patient who appears complaining of an emergency medical condition. It further provides that such patients cannot be transferred to another facility in an unstable condition, and requires that such a transfer be "appropriate" (emphasis added).

See also Johnson v. University of Chicago Hosp., 774 F. Supp. 510, 513 (N.D. Ill. 1991); Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990).

The Supreme Court of Virginia's reliance on Thornton v. Southwest Detroit Hospital, 895 F.2d 1131 (6th Cir. 1990), App. A 19-21, was misplaced. While it is true that in Thornton the patient was transferred after spending some twenty-one days in the hospital, she presented to the hospital emergency room with an emergency medical condition as envisioned by the Act. The Court in Thornton stated that "once a patient is found to suffer from an emergency medical condition in the emergency room, she can not be discharged until the condition is stabilized." 895 F.2d at 1134 (emphasis added). The court affirmed the district court's holding that COBRA was not applicable because the plaintiff was stabilized at the time of her release. Id. at 1135.

In contrast, the patient dumping statute does not apply to the instant case because Ms. Smith did not present to the emergency room of the Hospital. Nor has she alleged that when she came to the hospital that she was in an emergency condition or in active labor. Furthermore, she has admitted that during her five-day treatment at the Hospital she received stabilizing treatment. Given these facts, the trial court properly held that the plaintiffs had failed to state a cause of action under 42 U.S.C. § 1395dd and the Supreme Court of Virginia erred in holding otherwise.

While the plaintiffs made a conclusory allegation that Ms. Smith was transferred in violation of the statute, the facts pleaded made it obvious that the transfer occurred because "Richmond Memorial

Hospital does not have a Neonatal Intensive Care Unit and does not have the facilities to care for a premature infant, such as Taja Smith under the circumstances of the case." Motion for Judgment, ¶ 5. It was also alleged that Richmond Memorial Hospital "knew when it admitted Connie Smith to its hospital that it had inadequate facilities to care for a premature infant" and "knew or should have known that the patient Connie Smith should not be admitted to Richmond Memorial Hospital and/or should be transferred on a timely basis to another hospital with appropriate facilities." Id. ¶ 62.

Thus, Ms. Smith alleged not that the Hospital "dumped" her in violation of the Act, but that it should never have admitted her or having admitted her, that it should have treated her differently. Such claims

are not cognizable under the patient dumping statute, which addresses itself to a hospital's refusal to treat, not to misdiagnosis or inadequate treatment. See, e.g., Stewart v. Myrick, 731 F. Supp. 433 (D. Kan. 1990); Evitt v. University Heights Hosp., 727 F. Supp. 495, 497 (S.D. Ind. 1989); see also Petrovics v. Prince William Hosp. Corp., 764 F. Supp. 415, 417 (E.D. Va. 1991) (quoting Thornton v. Southwest Detroit Hosp., 895 F.2d 1131, 1133 (6th Cir. 1990) for the proposition that a patient dumping case is not analogous to a state medical malpractice claim because it creates liability for refusal to treat).

The treatment required to be given by a hospital is necessarily limited by "the staff and facilities available at the hospital." 42 U.S.C. § 1395dd(b)(1)(A). According to plaintiffs' own allegations,

a transfer to MCV, which unlike Richmond Memorial has a Neonatal Intensive Care Unit, was in the best interests of Connie Smith and her unborn child. Motion for Judgment, ¶5. The transfer was accomplished within twenty minutes. Id. ¶¶ 19 and 23. The dilation of Connie Smith's cervix was the same, one centimeter, before and after she was transferred, id. ¶¶ 11 and 30, and Taja Smith was not delivered at MCV for more than seven hours after her mother was admitted to MCV, id. ¶¶ 23 and 42. As the trial court stated: "At the time of the transfer, the condition of the mother and child required treatment beyond the resources available at defendant hospital....MCV had superior facilities to care for the condition of mother and child....Nothing indicates that the

transfer of a short distance was causally connected to the injury." App. B 18-19.

In holding that the motion for judgment stated a sufficient claim under the COBRA statute despite the absence of any allegation that Ms. Smith presented to the hospital's emergency department seeking a medical examination or treatment and was denied a screening examination or stabilizing treatment, the Virginia Supreme Court read the subsections of the statute in isolation, stating that "each subsection describes distinct patient circumstances requiring different treatment protocols." App. A-17. The court found nothing in the language of the statute which would limit subsections (b) and (c) to a patient who initially arrived at the emergency room and never received stabilizing treatment. Id. at 17-18. The court failed to apply

appropriate principles of statutory construction or to analyze the legislative history in order to discern the intent of Congress in passing the anti-dumping provisions. Id. at 18.

The Health Care Financing Administration ("HCFA") and the Office of the Inspector General of the Department of Health and Human Services are the agencies charged with the responsibility of administering and enforcing the anti-dumping provisions contained in § 1867 of the Social Security Act, 42 U.S.C. § 1395dd. In 1992, HCFA issued interpretative guidelines to state agencies that assist it in the investigation of complaints relating to the anti-dumping provisions of the statute. See App. E.

HCFA has instructed these agencies that the anti-dumping provisions do not

apply to all hospital transfers and that they do not apply to a patient beyond initial stabilization.

> The anti-dumping requirements continue to apply until the individual is properly examined, treated, stabilized and, if appropriate, either admitted to the hospital, discharged, or properly transferred, unless the individual or his/her representative refuses any of those services. This does not mean that the anti-dumping provisions apply to all hospital transfers. Once an individual's emergency medical condition is stabilized as defined under section 1867(e)(3) the hospital has met its obligations under this statute and it no longer is required to comply with the other anti-dumping documentation or transfer requirements (emphasis added).

App. E 6-7. Thus, HCFA construes COBRA "as applicable up to time of admission and until initial legal stabilization" and utilizes "patient safety standards for

subsequent transfer reviews." Frew Consulting Group, Ltd., "HCFA Issues COBRA Enforcement Policies," Critical Information Resource (March 1992).

The 1992 guidelines continue to reflect the same advice that HCFA has disseminated to providers all along concerning the applicability of subsections (b) and (c) of the Act to inpatient transfers. In preparing a special briefing for its member hospitals in 1990 on compliance with COBRA requirements, the American Hospital Association ("AHA") sought and received guidance from the Administrator of the Health Care Financing Administration, Gail Wilensky, see App. F-4; App. G; App. H, and communicated the following information to its members:

> Do the transfer protocols have to be observed for hospital inpatients?

> No. Taken together, these requirements describe a series of steps for the identification and treatment of individuals who come to a hospital's emergency department seeking care for an emergency medical condition. Many hospitals have questioned whether the requirements for transfer in this law would apply to hospital inpatients who develop emergency medical conditions and may need to be transferred to another facility. The logic of the law...suggests that it does not pertain to the transfer of hospital inpatients.

App. F 5-6.

In defining the scope of COBRA provisions, HCFA reads the requirements of subsections (a), (b) and (c) in context and applies the requirements of (b) and (c) regarding stabilizing treatment or appropriate transfer only to those individuals to whom subsection (a) refers, that is, individuals who have come to the emergency department of a hospital seeking medical treatment, who have been screened

and are determined to have an emergency medical condition. According to the HCFA policy statement, "all provisions of the anti-dumping statute, including the documentation and transfer requirements, are applicable once an individual with an emergency medical condition or a woman in labor presents him or herself and requests services at a Medicare participating hospital that has an emergency department" (emphasis added). App. E 5-6.

HCFA construes the subsections of the COBRA statute as interdependent rather than as isolated requirements. According to its enforcement guidelines, the six requirements contained in the statute apply only to hospitals that have an emergency department. App. E 9-17, 22-23. Subsection (a) provides that "[i]n the case of a hospital that has an emergency

department," an individual presenting to the emergency department seeking medical services must be given a screening examination in order to determine whether an emergency medical condition exists. 42 U.S.C.A. § 1395dd(a). This interpretation in HCFA's recently issued enforcement policies is consistent with the positions it has previously taken that the subsections of the COBRA statute must be read in conjunction with one another, not separately. See App. H and I.

HCFA's construction does not accord with the Virginia Supreme Court's emphasis in this case on the different phraseology in subsections (a), (b) and (c) -- "comes to the emergency department," "comes to a hospital," and "patient at a hospital," respectively -- and its conclusion that "each subsection describes distinct patient

circumstances requiring different treatment protocols." App. A-17. Presumably, the Virginia Supreme Court would read the subsection (a) requirement that the hospital have an emergency department out of subsections (b) and (c), just as it read out the requirement that the individual have presented to the emergency department.

HCFA's construction of the COBRA requirements is supported by the language of the statute itself. Section 1395dd (a) provides that when an individual comes to the emergency department of a hospital seeking medical services, the hospital must provide a medical screening examination "to determine whether an emergency medical condition exists." Subsection (b) provides that where "the hospital determines that the individual has an emergency medical condition, then the hospital must provide

stabilizing treatment or transfer the individual to another medical facility in accordance with subsection (c). The determination whether the individual has an emergency medical condition referred to in subsection (b) is the predicate to the duty in subsection (b) to provide stabilizing treatment or transfer and clearly flows from the requirements of subsection (a) that such a determination be made on behalf of individuals presenting to the emergency room. As the Virginia Supreme Court noted in this case, App. A-8, no such duty existed at common law.

Thus, subsection (b) is tied directly to subsection (a) and applies to a subset of the same class of individuals, that is, those individuals presenting to the emergency department of a hospital for medical examination or treatment who have

been determined to have an emergency medical condition. Subsection (b) specifically references subsection (c) regarding the manner in which such individuals may be transferred. Further evidence that subsection (c) applies to the same class of individuals defined in subsection (a) is found in § 1395dd(c)(1)(A)(ii) which refers to the availability of a physician "in the emergency department" as affecting who may sign the required certification for the transfer of an individual with an emergency medical condition which has not been stabilized. Unless subsection (c) refers to transfers from the emergency department this phrase has little if any meaning. Thus, subsections (a), (b) and (c) of the COBRA statute interrelate and describe the

hospital's continuing duty to a narrowly defined group of individuals.

Unlike the Virginia Supreme Court's construction of § 1395dd in this case, HCFA's interpretation of the law upholds a basic tenet of statutory construction -- that the statute be construed as a whole and that its individual sections or subsections be read in context. Erlenbaugh v. United States, 409 U.S. 239, 244 (1972); Crandon v. United States, 494 U.S. 152, 158, 164 (1990).

HCFA's interpretation of the law is supported by the legislative history of the anti-dumping provisions. The House Ways and Means Committee stated in its report that it was "greatly concerned about the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions if

the patient does not have medical insurance." H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. 27, pt. I, at § 17, reprinted in 1986 U.S. Code Cong. & Admin. News 579, 605 (emphasis added). The Committee on the Judiciary also noted in its report that "[i]n recent years there has been a growing concern about the provision of adequate emergency room medical services to individuals who seek care, particularly as to the indigent and uninsured." H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. 5, pt. III, reprinted in 1986 U.S.Code Cong. & Admin. News 726, 726 (emphasis added). The Committee recommended fines be imposed on a physician as well as a hospital "who fails to properly respond to the genuine medical needs of individuals who come to emergency rooms." Id. at 729 (emphasis added).

The COBRA amendment was described by two of its co-sponsors as attacking "the practice of dumping the sick and indigent from emergency rooms" and "addressing the critical problem of hospital emergency department dumping of the medically uninsured," 131 Cong. Rec. S13903, S13904 (October 23, 1985) (statements of Senators Durenberger and Heinz, respectively) (emphasis added). Senator Kennedy stated that the legislation was necessary, because while "[s]ome states have laws which ensure that no emergency patient is denied emergency care because of inability to pay ... 28 states have no such law. Federal legislation in this area is long overdue." 131 Cong. Rec. S13904 (October 23, 1985) (statement of Senator Kennedy). Congressional concern was clearly directed at the treatment, or lack thereof, of

indigent patients seeking emergency room services.

The Committee on the Judiciary defined the scope of the COBRA requirements as follows:

> This section requires a hospital which has a Medicare Provider Agreement and which operates an emergency department to provide an appropriate medical screening of any individual for whom a request for treatment is made. The purpose of this screening is to determine if an emergency medical condition exists or if the patient is in active labor. If the hospital determines that either condition exists, the hospital must provide further treatment to stabilize the individual or, if it determines to transfer the individual to another facility, it must properly complete this transfer.

H. R. Rep. No. 99-241, 99th Cong., 2nd Sess. 5, pt. III, reprinted in 1986 U.S.

Code of Cong. & Admin. News 726, 727. Likewise, the Committee on Ways and Means described the hospitals' obligations under the Act as follows: "[w]ithin their capacities, hospital emergency departments must provide appropriate treatment to stabilize patients who have emergency medical conditions or to provide treatment for patients in active labor, and provide for appropriate transfers." H.R. Rep. No. 99-241, 99th Cong., 2nd Sess. 4, pt. I, reprinted in 1986 U.S. Code of Cong. & Admin. News 579, 582 (emphasis added). No similar statement regarding necessary stabilizing treatment for inpatients was included. As Senator Dole stated, "[u]nder the provision of this amendment, a hospital is charged only with the responsibility of providing an adequate first response to a

medical crisis." 131 Cong. Rec. S13904 (statement of Senator Dole).

Thus, it is apparent that the problem identified and addressed by Congress by way of this legislation was the turning away of patients from the emergency departments of hospitals based primarily on their inability to pay. Furthermore, Congress was concerned that an adequate remedy did not otherwise exist because in many states there is no duty to treat emergency patients.

The Virginia Supreme Court expressed concern in the instant case that transferring an inpatient because his condition might result in substantial unreimbursed medical costs was equally reprehensible whether the patient arrived through the emergency room or not and whether he had been initially stabilized or

not. App. A 18-19. There is no evidence that Congress perceived that transfers outside of the emergency services area presented a problem, however.

As the Virginia Supreme Court acknowledged, a major impetus behind the enactment of the COBRA anti-dumping provisions was the fact that under the common law, hospitals had no duty to treat emergency patients. App. A-8. Thus, a federal cause of action was enacted where no common law action existed, at least in many states. With respect to the improper transfer of an inpatient, however, a common law cause of action does exist, because of the attachment of the physician-patient relationship, see, e.g., Lyons v. Grether, 218 Va. 630, 634, 239 S.E.2d 103, 106 (1977), and as a result of the implied contract between the patient and the

hospital, see, e.g., Stuart Circle Hospital v. Curry, 173 Va. 136, 146-47, 3 S.E.2d 153, 157 (1939). Having assumed the duty to treat, the physician and the hospital are required to do so in a non-negligent manner.

HCFA has construed the COBRA requirements as evidenced in its recently issued guidelines to state agencies, App. E, and in earlier letters responding to inquiry from the American Hospital Association and from hospital counsel, App. H and I, to mean that there is no continuing COBRA duty after initial stabilization and that subsections (b) and (c) apply only to those persons presenting themselves to a hospital's emergency department under subsection (a). This construction accords not only with the

letter of the law, but with Congress' legislative intent, as outlined above.

The construction of a statute by the administrative agency that is charged with the responsibility of enforcing it is entitled to great deference. See Chevron U.S.A. Inc. v. Natural Resources Defense Council, 467 U.S. 837, 842-43 (1984); see also C. Koch, Administrative Law and Practice § 3.53 (1985). It is incongruous for private litigants in the Commonwealth of Virginia to be proceeding under a construction of the COBRA statute rendered by the state supreme court which directly conflicts with the construction of the statute utilized by state agencies in Virginia assisting HCFA in investigating COBRA complaints.

The Court should grant the Hospital's petition for certiorari on this issue

because the Virginia Supreme Court's interpretation of COBRA conflicts with the language of the statute, clearly expressed Congressional intent and the interpretation of the federal regulatory agency charged with administering the law.

II. THE NOTICE OF CLAIM AND PANEL REQUIREMENTS OF VIRGINIA'S MEDICAL MALPRACTICE ACT ARE NOT PREEMPTED BECAUSE THEY DO NOT DIRECTLY CONFLICT WITH ANY REQUIREMENT OF COBRA

Section 1395dd(f) provides that the COBRA provisions do not "preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section." The Supreme Court of Virginia held that the notice of claim and review

panel provisions[4] of the Virginia Medical Malpractice Act, Va. Code Ann. § 8.01-581.2, are not applicable to a COBRA claim because they would directly conflict with the two-year statute of limitations prescribed in 42 U.S.C. § 1395dd(d)(3)(C). App. A-34.

As the court noted, the notice of claim provisions prohibit a plaintiff from filing suit until 90 days after written notice of the claim is given to the health care provider, and, if the provider

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[4] Unless preempted by COBRA, the notice of claim provision would apply to the instant case, because it applies to all malpractice actions, § 8.01-581.2, and "malpractice" is defined as "any tort based on health care or professional services rendered, or which should have been rendered, by a health care provider," Va. Code Ann. § 8.01-581.1. In Glisson v. Loxley, 235 Va. 62, 67, 366 S.E.2d 68, 71 (1988), the Virginia Supreme Court defined "tort," in the notice of claim context, as "the violation of some duty owing to the plaintiff imposed by the general law or otherwise."

requests that the issue be reviewed by a malpractice review panel, until the panel completes its review. App. A-32. Section 8.01-581.9 of the Medical Malpractice Act, however, tolls "the applicable statute of limitations for a period of 120 days from the date such notice is given, or for 60 days following the date of issuance of any opinion by the medical review panel" (emphasis added). The court stated that this tolling provision can toll only a state statute of limitations, App. A 32, 33-34. The court reasoned that the notice of claim provisions directly conflicted with the two-year COBRA statute of limitations because compliance with the notice provisions of the Virginia statute could result in the inability of a litigant to file a claim within the limitations period. App. A-34.

There is no direct conflict which preempts either the notice of claim[5] or the tolling provision. Burrows v. Turner Memorial Hospital, 762 F. Supp. 840, 843 (W.D. Ark. 1991), the sole authority relied upon by the Virginia Supreme Court for the proposition that a state tolling statute can not toll a federally prescribed statute of limitations, is inapposite, because Burrows and the cases cited therein address whether a state statute will toll a federal statute of limitations for a federal cause

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[5] See Draper v. Chiapuzio, 755 F. Supp. 331 (D. Ore. 1991) (holding that Oregon's notice of wrongful death claim against public body applies to patient dumping claim); see also Wilson v. Atlanticare Medical Center, 868 F.2d 34, 35 (1st Cir. 1989) (While the court did not reach the question whether state malpractice panel referral and notice requirements apply to a patient dumping action, it observed that "hospitals...need screening protection against frivolous claims as much under the federal statute as they do for other malpractice charges.")

of action filed in federal court. Where a federally created cause of action is filed in state court, state procedural rules regarding commencement and tolling apply, even where the statute of limitations is federally prescribed. See 2 J. Moore, J. Lucas, H. Fink, & C. Thompson, Moore's Federal Practice ¶ 3.09[2]n.15 (2d ed. 1991).

Inasmuch as the Virginia Supreme Court has wrongly decided that there is a direct conflict between COBRA and Virginia's Medical Malpractice Act notice of claim provisions, thereby preempting the State law and depriving Virginia hospitals of an important right, the Hospital's petition for certiorari on this issue should be granted.

CONCLUSION

For the reasons stated above, the Hospital's petition for certiorari should be granted.

Respectfully submitted,

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September 3, 1992

APPENDIX A

Present: Carrico, C.J., Compton, Stephenson, Whiting, Lacy, and Kennan, JJ., and Cochran, Retired Justice

OPINION BY JUSTICE
ELIZABETH B. LACY
April 17, 1992

TAJA SMITH, AN INFANT, ETC., ET AL.

v. Record No. 910585

RICHMOND MEMORIAL HOSPITAL

FROM THE CIRCUIT COURT OF THE
CITY OF RICHMOND
Robert L. Harris, Sr., Judge

In this case we consider whether the trial court properly sustained a demurrer without leave to amend on the ground that the motion for judgment failed to state a cause of action under the Emergency Medical Treatment and Women in Active Labor provisions of the Consolidated

Omnibus Budget Reconciliation Act (COBRA or the Act), 42 U.S.C. § 1395dd (1988).

The circumstances of this case involve the medical treatment of a pregnant woman who subsequently gave birth to a child. We recite the facts as set out in the pleadings, taken as true for the purposes of reviewing the trial court's action on the demurrer. Bowman v. State Bank of Keysville, 229 Va. 534, 536, 331 S.E.2d 797, 798 (1985).

Connie Elizabeth Smith was admitted to Richmond Memorial Hospital (the Hospital) as a patient on July 18, 1988. Ms. Smith was approximately 33 weeks pregnant and had premature rupture of the uterine membranes. Ms. Smith remained at the Hospital until July 23, 1988.

During the afternoon of July 22, 1988, Ms. Smith complained of abdominal cramping and vaginal leakage. The discharge had turned to a greenish yellow color. In the afternoon and again at 10:00 p.m. she was given Nembutal, a hypnotic drug. By 10:00 p.m., Ms. Smith was complaining of irregular abdominal pain and contractions. By 10:30 p.m., her contractions were timed at five minute intervals. At 11:45 p.m., she was taken to the labor and delivery facilities of the Hospital. The vaginal discharge was now dark green in color. By midnight, the opening to the patient's uterus had dilated one centimeter, she had cold chills, and her temperature had dropped to 95.3 degrees Fahrenheit.

At 1:00 a.m., the Hospital called a physician, who ordered that Ms. Smith be transferred to the Medical College of Virginia Hospital (MCV). The physician was not Ms. Smith's regular attending physician, and he gave the verbal transfer order without examining her. Following the transfer order, a nurse began trying to locate an ambulance service to transfer Ms. Smith to MCV. Two services refused, and one was not obtained until the Richmond Memorial administrator agreed that the cost of the transfer could be billed to MCV. Connie Smith was taken from the Hospital at 2:10 a.m. and was admitted to MCV at approximately 2:30 a.m. on July 23, 1988.

A medical resident at MCV assessed Ms. Smith's condition to be "(1)

prolonged premature rupture of the membranes, (2) pre-term labor at 34 weeks, (3) the Chorioamnionitis should be ruled out, and (4) that there was questionable meconium discharge." At 3:00 a.m., Ms. Smith signed a consent for a caesarean delivery, if necessary. Her contractions were one to five minutes apart at 4:20 a.m. She was taken "emergently" to the delivery room where the child, Taja Smith, was delivered by caesarean operation at approximately 9:48 a.m. Both mother and child suffered substantial injuries. Taja has cerebral palsy and is severely brain damaged.

Ms. Smith sued Richmond Memorial Hospital in her individual capacity and on behalf of her daughter Taja (collectively Smith), claiming a

violation of COBRA and seeking damages. The Hospital demurred on three grounds: (1) the claims are "actually those alleging medical malpractice" and, therefore, the circumstances alleged cannot support a claim against the Hospital under COBRA; (2) no actionable claim under COBRA was stated because Smith did not allege that indigency was the motivating reason for the transfer from Richmond Memorial Hospital to MCV; and (3) no notice of claim as required by Code § 8.01-581.2 was given.

The trial court first determined that Code § 8.01-581.2 notice of claim provisions were inapplicable to claims based on a COBRA violation. Next, stating that the "crux of the issue presented by plaintiff is that she

remained at Richmond Memorial without adequate care," the trial court held that COBRA does not cover "emergency conditions arising from medical neglect during a stay in a hospital." Accordingly, the trial court agreed with the Hospital's argument that Smith's claim was actually one for medical malpractice and held that a cause of action under COBRA was not sufficiently pled. The trial court sustained the demurrer without leave to amend.

We awarded Smith an appeal. We also granted a review of the Hospital's assignment of cross-error regarding the applicability of the notice of claim

provisions of Code § 8.01-581.2 to claims filed under COBRA.[1]

I.

Congress enacted COBRA in 1986 in response to the growing number of instances in which hospitals were refusing to treat individuals with emergency medical conditions, a practice generally referred to as "patient dumping." Under the common law, private hospitals have no duty to accept or to provide treatment for patients. While private hospitals traditionally did treat people in emergency situations, they

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[1]Although the Hospital argues on brief that an allegation of economic motivation for the transfer was an essential pleading requirement in this case, the trial court did not rule on this argument, and that issue is not before us.

generally were not fully compensated, or were not compensated at all, for treatment of indigent patients. With growing competition among hospitals, shifting this cost to paying patients became more difficult. As the hospitals' economic losses increased, the instances of patient dumping also increased. To counteract patient dumping and the resultant hardship and injury, COBRA established specific standards for the evaluation, treatment, and transfer of patients. Abercrombie v. Osteopathic Hosp. Founders Ass'n, 950 F.2d 676, 680 (10th Cir. 1991); Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1039 (D.C. Cir. 1991); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 268 (6th Cir. 1990); Andrew Jay McClurg,

Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping, 24 Wake Forest L. Rev. 173, 197-99 (1989); Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the Cobra's Fangs, 61 N.Y.U. L. Rev. 1186, 1187-88 (1986).

II.

The Hospital argues that Smith did not plead a claim under COBRA for two reasons. First, asserting that coming to an emergency room in an emergency medical condition or in active labor is a prerequisite to the application of the treatment and transfer provisions of subsections (b) and (c) of the Act, the Hospital argues that Smith's claim fails because she did not plead that she came

to the emergency room in such a condition. Furthermore, the Hospital asserts that Smith's admission that her condition had been stabilized prior to the events giving rise to her transfer to MCV absolves the Hospital from liability under COBRA. Second, the Hospital argues that Smith's claim is one for misdiagnosis or improper treatment, and, therefore, that it is not cognizable under COBRA. In response, Smith contends that, under the Act's language, a patient need not be transferred from an emergency room to establish a COBRA cause of action, and that a hospital cannot escape COBRA liability by "initially stabilizing a patient, allowing the patient to again become unstable, and then transferring the patient."

Although framed in terms of the sufficiency of the pleading, the crux of the issue in this case is one of statutory interpretation: (1) whether COBRA's treatment and transfer requirements are limited solely to an emergency medical condition or active labor which has not been stabilized and which occurs in conjunction with initial admission to an emergency department; or (2) whether those requirements also apply when an emergency medical condition or active labor commences after the admission and initial stabilization of the patient's condition.

To resolve the parties' conflicting interpretations, we begin with an examination of the Act itself. At the

time of the alleged violation, 42 U.S.C. § 1395dd stated in relevant part:

> (a) **Medical screening requirement**
>
> In the case of a hospital that has a hospital emergency department, <u>if any individual</u> (whether or not eligible for benefits under this subchapter) <u>comes to the emergency department</u> and a request is made. . . for examination or treatment . . . the hospital must provide for an appropriate medical screening examination . . . to determine whether or not an emergency medical condition . . . exists or to determine if

the individual is in active labor . . . .

(b) **Necessary stabilizing treatment for emergency medical conditions and active labor**

(1) In general

If any individual (whether or not eligible for benefits under this subchapter) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either -

(A) . . . such further medical examination and such treatment as may be required to stabilize the medical condition or . . . provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c) of this section.

. . .

(c) **Restricting transfers until patient stabilized**

(1) Rule

If a patient at a hospital has an emergency medical condition which has not been stabilized . . . or is in active labor, the hospital

may not transfer the patient unless -

> (A)(i) the patient . . . requests that the transfer be effected, or
>
> (ii) a physician . . . or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that . . . the medical benefits reasonably expected from the . . . [transfer] outweigh the increased risks to the individual's medical condition from effectuating the transfer . . . .

(Emphasis added.)

The language used in each subsection describes distinct patient circumstances requiring different treatment protocols. If an individual "comes to the emergency department," the hospital must provide an appropriate medical screening examination. Id. at § 1395dd(a). If an individual "comes to a hospital" and the hospital determines that an emergency medical condition or active labor exists, the hospital must stabilize the condition or transfer the person. Id. § 1395dd(b). If a "patient at a hospital" has an emergency condition or is in active labor, the hospital may transfer that patient only under certain conditions. Id. § 1395dd(c).

The statutory language clearly requires a patient to be in an emergency

medical condition or to be in active labor before the provisions of subsections (b) and (c) apply. But we find nothing in the language of the Act which limits application of these subsections solely to a patient who initially arrives at the emergency room and who has not been stabilized, as the Hospital argues here. When the words of the statute are plan and unambiguous we need not resort to rules of statutory construction or legislative history. Marsh v. City of Richmond, 234 Va. 4, 11, 360 S.E.2d 163, 167 (1987).

This interpretation of the Act is consistent with the legislation's purpose. Patient dumping is not limited to a refusal to provide emergency room treatment. See Thompson v. St. Anne's

Hosp. , 716 F.Supp. 8 (N.D. Ill. 1989). It occurs, and is equally reprehensible, at any time a hospital determines that a patient's condition may result in substantial medical costs and the hospital transfers the patient because it fears it will not be paid for those expenses. Dumping a patient in this manner is neither related to, nor dependent upon, the patient arriving through the emergency room and never being stabilized.

We are unaware of any case which has addressed this specific issue. The rationale of two cases considering the construction and purpose of the Act, however, is consistent with our interpretation of the statutory language. In Thornton v. Southwest Detroit Hosp.,

895 F.2d 1131 (6th Cir. 1990), a patient was taken to a hospital emergency room and then admitted to the intensive care unit where she was treated for ten days. She was later transferred to regular in-patient care where she was treated for another 11 days and was then discharged. After examining the use of the words "emergency room" and "hospital" in subsections (a), (b), and (c) of the Act, the court rejected the Hospital's argument that the Act's requirement of care for a patient did not extend beyond the emergency room to the intensive care and in-patient areas. The court reasoned that COBRA was intended to "insure that patients with medical emergencies would receive emergency care . . . [which] does not . . . stop when a patient is wheeled

from the emergency room into the main hospital." Id. at 1135.

The rationale of Thornton was cited and utilized in Loss v. Song, No. 89C 6952, 1990 WL 159612 (N.D. Ill. 1990) (mem.). There, the hospital argued that a child with an emergency medical condition who was born at the hospital was precluded from bringing an action under COBRA because the child could not plead that he was admitted to or through the emergency room. The Loss court allowed the child's case to proceed, holding that allegations that "from the moment he was born in the defendant hospital, [he] suffered from a severe congenital cardiac disease" were sufficient to state a claim under COBRA. Id. at *4. In both of these cases, the

court examined the statutory language and found that it required the treatment of medical emergency conditions, irrespective of the manner in which the patient arrived at the institution or where within the hospital the treatment was provided.

The Hospital relies on specific language in three cases to support its argument that a plaintiff must allege arrival at an emergency room to state a cause of action under COBRA. The precedential value of those statements to this case is diminished, however, in light of the specific facts of the cases. In Johnson v. University of Chicago Hosp., 774 F.Supp. 510 (N.D. Ill. 1991), the patient was never taken to the emergency room of the defendant hospital,

nor was she ever even present in the hospital. The issue in Deberry v. Sherman Hosp. Ass'n, 741 F.Supp. 1302 (N.D. Ill. 1990), was whether stating a claim under COBRA required pleading that the hospital's failure to treat was based on the patient's inability to pay.[2] Statements regarding the need to plead an arrival or physical presence at an emergency room, unaccompanied by any issues or facts analogous or similar to those in the instant case, are neither determinative nor persuasive.

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[2]Loss, supra, and Deberry were both decided in the Federal District Court for the Northern District of Illinois. In Loss, the court acknowledged its prior statement in Deberry that a "would-be COBRA plaintiff" must plead presentation to the emergency room, but did not consider that statement as applying in all COBRA cases. Loss, 1990 WL 159612 at *3.

Finally, the Hospital cites the following passage from Owens v. Nacogdoches County Hosp. Dist., 741 F.Supp. 1269 (E.D. Tex. 1990), as dispositive of the issue:

> To address these problems, 42 U.S.C. § 1395dd requires that any hospital with an emergency room must provide a medical screening examination to any patient who appears complaining of an emergency medical condition. It further provides that such patients cannot be transferred to another facility in an unstable condition, and requires that such a transfer be "appropriate."

(Emphasis added). Id. at 1272. This passage appears in the court's general discussion of the Act entitled "I. Background-42 U.S.C. § 1395dd." It is neither the result of an analysis of the specific provisions of the Act nor part of any holding made by the court in conjunction with the issues in the case. Reliance on a single word contained in an abstract discussion of the general nature is misplaced, and provides no support for the Hospital's position in this case.

Although the legislative history of COBRA indicates Congressional concern with denial of treatment and inappropriate transfers of indigent persons who come to the emergency rooms of hospitals, the plain language Congress chose does not limit the Act to those

circumstances. Many courts called on to interpret the language of the Act have reached similar conclusions regarding the breadth of coverage the statutory language provides, in contrast to the more focused scope reflected in the legislative history of the Act. See e.g., Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414-15 (9th Cir. 1991); Gatewood, 933 F.2d at 1040; Lee by Wetzel v. Alleghany Regional Hosp. Corp., 778 F.Supp. 900, 902 (W.D. Va. 1991); Delaney v. Cade, 756 F.Supp. 1476, 1485-86 (D. Kan. 1991). As stated by the court in Cleland v. Bronson Health Care Group, Inc.:

> The words of the statute . . . are quite plain, and interpreting them as such does not lead to an absurd

> result. It leads to a result considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of. However, it is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress. . . . Here, the result we reach in no way vitiates or is contrary to Congress's indicated concern in passing the legislation. It may go further than what Congress contemplated, but that is not a reason to distort or excise the words that Congress wrote.

917 F.2d at 270.

We agree with this rationale, and it is equally applicable in this case. The words of the statute are plain, and our interpretation of those words does not subvert the purpose of the legislation or lead to an absurd result. Accordingly, we hold that the transfer provisions of § 1395dd(c) are applicable to situations in which a patient in a hospital has an emergency medical condition or is in active labor as defined by the Act.

Turning to the sufficiency of the pleadings, Smith alleged, inter alia, that just prior to transfer she was suffering from pains and abdominal cramping, had discolored vaginal discharge, experienced a temperature drop, and had frequent uterine contractions, and had begun to dilate.

The pleadings also state that no certificate such as is required by § 1395dd(c)(1)(A)(ii) was executed in conjunction with Smith's transfer to MCV. These facts, along with the allegations that Smith was in active labor and had an emergency medical condition at the time of the transfer and that the Hospital did not comply with the requirements for transfer, are sufficient to state a claim under COBRA.[3]

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[3]In light of this holding we do not address the Hospital's second argument, that the claim is actually one of misdiagnosis or improper treatment. The Hospital admits that a medical malpractice and COBRA claim can exist simultaneously and we have held that a COBRA claim has been plead. Whether the COBRA claim here is in reality only a traditional malpractice claim, as the Hospital argues, is an issue of fact, not pleading, and might be the subject of a motion for summary judgment as in Stewart v. Myrick, 731 F.Supp. 433 (D. Kan. 1990), and Evitt v. University Heights Hosp., 727 F.Supp.

III.

Because the action of the trial court in sustaining the Hospital's demurrer will be reversed and the case remanded for the reasons stated above, we must consider the Hospital's assignment of cross-error. The Hospital asserts that the trial court erred in holding that the notice of claim provisions of Va. Code § 8.01-581.2 are inapplicable to claims under COBRA. We disagree with the Hospital.

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495 (S.D. Ind. 1989). See also Anadumakav v. Edgewater Operating Co., No. 91 C 5374, 1992 WL 6726 (N.D. Ill. 1992); Coleman v. McCurtain Memorial Medical Management, Inc., 771 F.Supp. 343 (E.D. Okla. 1991); Lee, 778 F.Supp. at 903. Compare Deberry v. Sherman Hosp. Ass'n, 741 F.Supp. 1302 (N.D. Ill. 1990) with Deberry v. Sherman Hosp. Ass'n, 769 F.Supp. 1030 (N.D. Ill. 1991).

Subsection (f) of COBRA provides that:

> The provisions of this section do not preempt any state or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

The Hospital argues that the state notice of claim provisions do not conflict with COBRA. In support of this position, the Hospital cites Draper v. Chiapuzio, 755 F.Supp. 331, 333 (D.Or. 1991), which held that the Oregon requirement that notice of a wrongful death claim against a public body be filed within one year after the death did not conflict with COBRA. The Oregon statute, however,

involved only a simple notice of claim, which is a significant distinction.[4]

The Virginia notice provisions not only require a plaintiff to provide written notice of the claim to the health care provider, they also absolutely prohibit the filing of a medical malpractice claim against the health care provider until 90 days after such notification and, if the health care provider chooses to have the issue reviewed by a malpractice review panel, the suit cannot be filed until the panel completes its review. Code § 8.01-581.2(A). The state statute of limitations is tolled during this period.

---

[4]We also note that the complaint in Draper was not limited to a cause of action under COBRA as was the complaint here, but also included a cause of action for common law negligence.

It is this aspect of the notice of claim provision which is in direct conflict with the provisions of COBRA.

Subsection (d)(3)(C) of COBRA establishes a two-year statute of limitations for the filing of claims under the Act. COBRA establishes a separate federal cause of action, cognizable in federal and state courts, independent of any additional or pendant state claims. Sorrells v. Babcock, 733 F.Supp. 1189 (N.D. Ill. 1990); Reid v. Indianapolis Osteopathic Medical Hosp. Inc., 709 F.Supp. 853 (S.D. Ind. 1989); Bryant v. Riddle Memorial Hospital, 689 F.Supp. 490 (E.D. Penn. 1988). The tolling provisions of the state statute cannot act to toll the running of the statute of limitations established in

federal legislation which created a federal right of action. Burrows v. Turner Memorial Hosp., Inc., 762 F.Supp. 840, 843 (W.D. Ark. 1991).

Unlike the Oregon requirement, the Virginia notice of claim provision is not restricted to a mere notice. Compliance with the notice provisions of the Virginia statute could result in the inability of a litigant to file a claim within the COBRA two-year statute of limitations period. Consequently, we hold that the trial court correctly ruled that the notice of claim provisions of Code § 8.01-581.2 conflict with the requirements of COBRA and, therefore, are inapplicable to COBRA causes of action.

For the reasons discussed above, the judgment of the trial court will be

affirmed in part and reversed in part, and the case remanded for further proceedings.

Affirmed in part,
reversed in part, and remanded.

APPENDIX B

Circuit Court
of the
City of Richmond
John Marshall Courts Building

March 8, 1991

Robert L. Harris, Sr.
Judge

800 East Marshall Street
Richmond, Virginia 23219

Edward W. Taylor, Esq.
Taylor & Schockemoehl, P.C.
601 North Courthouse Road
Richmond, VA 23236

Richard Tyler McGrath, Esq.
Crews & Hancock
Suite 1015, Seven Hundred Building
Post Office Box 1474
Richmond, VA 23212-1474

Gentlemen:

Re: Taja Smith, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith and Connie Elizabeth Smith Individually v. Richmond Memorial Hospital
Case No. LS 2441-2

This matter comes before the court on Defendant's demurrer. The demurrer is sustained without leave to amend.

"A demurrer admits the truth of all material facts that are properly pleaded. According to this rule, the facts admitted are those expressly alleged, those which are impliedly alleged, and those which may be fairly and justly inferred from the facts alleged." Elliott v. Shore Stop, Inc., 238 Va. 237, 384 S.E.2d 752 (1989). Cognizant of these principles, the facts presented are as follows.

On July 18, 1988 plaintiff Connie Smith, a pregnant woman, hereinafter referred to as "mother" became a patient at defendant Richmond Memorial Hospital, hereinafter referred to as "Richmond Memorial." At the time of admission, mother had premature rupture of the membranes, with only a small amount of

fluid remaining. The gestational age of Taja Smith, hereinafter referred to as "child", was estimated to be approximately 32.5 to 33 weeks.

Mother remained at Richmond Memorial Hospital from July 18 until July 23 at which time she was transferred to Medical College of Virginia Hospital, hereinafter referred to as "MCV". During her stay at Richmond Memorial her condition deteriorated and she continued to leak fluid. By 4:30 p.m. on July 22 the leakage from her vagina had turned greenish yellow in color, and she experienced abdominal cramping. By 11:45 p.m. that night the discharge was dark green in color and she experienced frequent contractions. At midnight on July 22 she was dilated one centimeter.

Several hours later she suffered cold chills and a temperature drop to 95.3° F.

At 2:10 a.m. on July 23 mother was transferred by ambulance to MCV. Shortly after admission to MCV, her temperature elevated to 100.2° F. A cesarean operation was performed on the mother and delivery of the child occurred at 9:48 a.m. on July 23. The estimated gestational age at birth was determined to be 36 weeks.

The child was placed in the neonatal intensive care unit of MCV. She was resuscitated at birth, but several hours later experienced seizures. MCV continued to treat the child until her discharge on September 6. Her discharge diagnosis was:

1. Asphyxia neonatorum;

2. Grade Three ventricular hemorrhage with subsequent Hydrocephalus;

3. E-Coli Sepsis;

4. Seizure disorder; and

5. Hyperbilirubinemia.

Both mother and child suffered substantial injuries. The child has cerebral palsy. Because of her severe brain damage she is unable to speak, walk, stand, feed herself or control her elimination. Subsequent medical treatment was administered to the child for her personal injuries. After delivery, the mother experienced additional complications. Her womb had to be reopened due to infection and she developed bowel obstruction.

Plaintiff filed a motion for judgment on July 17, 1990 alleging violation of the Emergency Medical Treatment and Women in Active Labor provision of the Consolidated Omnibus Budget Reconciliation Act (COBRA), 42 U.S.C. § 1395dd. This statute is often referred to as the "patient dumping law." The motion for judgment contained no other counts.

Under common law, a hospital had no affirmative duty to treat a patient. Hospitals were free to refuse treatment or transfer to another institution those patients that were either unable to pay or were anticipated to be financially unprofitable. That practice was commonly referred to as "patient dumping." In the mid 1980's public scrutiny was focused on

several highly publicized cases of hospitals dumping patients in dire need of emergency care. In the resulting public outcry for the elimination of this practice, the patient dumping law was passed by Congress.

Compliance with the Act has become a conditional prerequisite of Medicare participation. The provisions of the statute include screening any individual presented to the emergency department, and furnishing treatment until the patient is stabilized or delivering the child of a woman in active labor. Additionally, the Act provides for the transfer of a patient to another institution.

The statute includes enforcement mechanisms to ensure compliance. The hospital's provider contract may be terminated or suspended by the Secretary of the Department of Human Services. Additionally, civil penalties may be imposed for violation. Finally, the statute authorizes a private cause of action against the transferring hospital.

Section 1395dd (d)(3)(A) of the Act states:

> Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of

the State in which the hospital is located, and such equitable relief as is appropriate.

The forum available to the private action is not stated in the Act. Therefore, ambiguity exists on the face of the statute. Brown v. Lukhard, 229 Va. 316, 330 S.E.2d 84 (1985). When ambiguity exists in statutory language, legislative history and extrinsic facts may be reviewed to determine the meaning. Va. Dept. of Labor & Industry v. Westmoreland Coal, 233 Va. 97, 353 S.E.2d 758 (1987).

The Committee on Ways and Means which reviewed H.R. 3128 stated that a private enforcement action may be brought "in an appropriate state or Federal district court . . . ." H.R. Rep. No. 241(I) 99th Cong., 1st Sess. 28,

reprinted in 1986 U.S. Code Cong. & Admin. News 606. The Committee on the Judiciary subsequently reviewed the Committee on Ways and Means' report, reaching the same conclusion that state and federal courts should have concurrent jurisdiction. H.R. Rep. No. 241 (III), 99th Cong., 1st Sess., 7, reprinted in 1986 U.S. Code Cong. & Admin. News 729.

Legislative history was cited in Bryant v. Riddle Memorial Hosp., 689 F. Supp. 490 (E.D. Pa. 1988) in support of the conclusion that a private action could be initiated in federal court. The legislative history similarly compels the conclusion that there is concurrent jurisdiction in state court.

Jurisdiction being proper in this court, we shall review the substantive

issues presented. Defendant demurs on three grounds. Initially we shall consider whether plaintiffs were required to give notice of their claim pursuant to Va. Code § 8.01-581.2 prior to initiating a COBRA action.

Pursuant to Va. Code § 8.01-581.2(A) a plaintiff must first serve a Notice of Claim upon the allegedly negligent health care provider before bringing a medical malpractice action. Within 60 days, the health care provider may request a review of the claim by an appointed medical malpractice review panel. If the health care provider requests a panel, suit may not be filed until completion of the review.

Plaintiffs have never mailed a Notice of Claim to defendant and have not

coupled a state medical malpractice claim with the COBRA count in the action before the court. The patient dumping count is the sole count in the Motion for Judgment. Defendant has demurred to the action based on the failure to file notice of claim.

Whether the procedural requirements of state medical malpractice claims are applicable to the COBRA claim has been considered with differing results by several federal courts. Draper v. Chiapuzio, No. 90-7909-FR (D. Or. Jan. 28, 1991) (available on Westlaw, Allfeds library, 1991 WL 10027 (D.Or.)); Toliver v. Culpeper Memorial Hospital, Inc., Civil Action No. 90-0501-A, memorandum opinion (Aug. 30, 1990); Reid v. Indianopolis Osteopathic Medical

Hospital, 709 F. Supp. 853 (S.D. Ind. 1989).

In Toliver, supra, the court determined that application of the Virginia procedural limitations would contravene the intent of the patient dumping law. "Any conclusions by a state review panel convened to explore the possibilities of negligence by a local health care provider are logically irrelevant to the federal equation and directly at odds with its spirit. Congress could not have intended such an absurd result." Id. at 7. The court conceded that "the Virginia statute depriving its courts the jurisdiction to hear medical malpractice claims while a review panel is convened to make a preliminary inquiry will not be

applicable to the plaintiffs' federal COBRA claims." Id. at 8.

The issue presented in the case at hand is analogous to that presented in Toliver. In Toliver the court determined that the state statute depriving jurisdiction while a panel was convened was inapplicable to the federal patient dumping cause of action. Similarly, I find that the provision of § 8.01-581.2(A) which provides "No action may be brought for malpractice against a health care provider unless the claimant notifies the health care provider in writing by registered or certified mail prior to commencing the action" is likewise inapplicable. All state imposed limitations of § 8.01-581.2 are inapplicable to this federal cause of

action, regardless of whether the patient dumping claim is brought in state or federal court.

Defendant's demurrer alleges that plaintiff's claim is actually one for medical malpractice. I find this argument compelling and sustain the demurrer on this ground.

The legislative history of the Act indicates that it was passed to eliminate the practice of some hospitals of rejecting persons in emergency conditions. The patient dumping law does not generally preempt state medical malpractice law. Evitt v. University Heights Hospital, 727 F. Supp. 495, 497 (S.D. Ind. 1989).

The plaintiff's interpretation reaches beyond the purpose of the

statute, which is specifically directed toward preventing prospective patients from being turned away for economic reasons.

Underlying plaintiff's reading of the screening provision is her implicit complaint that she was misdiagnosed. Following her reasoning, if [her physician] had suspected she was having a heart attack, he would have ordered a 12-lead EKG, which would have confirmed his suspicions and led to the plaintiff's admission and further treatment. This complaint, rather than focusing on the "dumping" problem, begins by attacking the doctor's provisional

> diagnosis. Claims regarding diagnosis and treatment lie in the area of medical malpractice, an area traditionally regulated by state law. To adjudicate these issues under the anti-dumping provision would lead to federal preemption not contemplated under this Act.

Evitt, supra. at 497 (citations omitted).

In Evitt, Id. and Stewart v. Myrick, 731 F. Supp. 433 (D.Kan. 1990), the court concluded that the patient dumping law was not intended to guarantee proper emergency room diagnosis and treatment. I concur that the Act was never intended for this purpose.

Under the facts pleaded in the case at hand, mother was admitted to Richmond

Memorial on July 18 and was permitted to stay in the hospital with little treatment, for five days. Unfortunately, she was kept at the hospital with improper care. At the time of transfer, the condition of mother and child required treatment beyond the resources available at defendant hospital.

The Act does not insure that emergency conditions arising from medical neglect during a stay in a hospital would be enveloped by the Act. Plaintiff's motion for judgment contains allegations of standard negligence. The crux of the issue presented by plaintiff is that she remained at Richmond Memorial without adequate care. When Richmond Memorial realized the seriousness of mother's condition, they transferred her to MCV.

MCV had superior facilities to care for the condition of mother and child. Regretfully, the treatment and transfer to MCV was delayed, causing damage to plaintiffs. Nothing indicates that the transfer of a short distance was casually connected to the injury.

Under the facts presented, a cause of action for patient dumping is not sufficiently pleaded. Demurrer is sustained without leave to amend. However, once there has been compliance with the necessary procedures, this court will entertain a medical malpractice claim among these parties, provided the statute of limitations has not run.

Very truly yours,

ROBERT L. HARRIS, SR.

RLH/vgt

VIRGINIA:

IN THE CIRCUIT COURT OF THE CITY OF RICHMOND, JOHN MARSHALL COURTS BUILDING

THE 8TH DAY OF MARCH 1991

TAJA SMITH, an infant who sues by her friend and mother, Connie Elizabeth Smith and Connie Smith Individually

Plaintiffs,

vs. LS 2441-2

RICHMOND MEMORIAL HOSPITAL,

Defendant

ORDER

On October 9, 1990 came the parties, by counsel, on the Demurrer of Defendant.

Upon consideration of the pleadings and argument of counsel and for the reasons stated in the letter opinion of this date, it is hereby Ordered and Decreed that the Demurrer is sustained without leave to amend. This case is dismissed, stricken from the docket, and

the clerk is directed to place it among the ended causes.

Endorsements pursuant to Rule 1:13 are not required, as this decision has been orally announced to the parties.

The Clerk is directed to send a certified copy of this order to all counsel of record.

ENTER: March 8, 1991

_____

Judge

APPENDIX C

VIRGINIA:

In the Supreme Court of Virginia held at the Supreme Court Building in the City of Richmond on Friday *the* 5th *day of* June, 1992.

Taja Smith, an Infant, etc., et al., Appellants,

against Record No. 910585
Circuit Court No.
LS-2441-2/91-693

Richmond Memorial Hospital, Appellee.

Upon a Petition for Rehearing

On consideration of the petition of the appellee to set aside the judgment rendered herein on the 17th day of April, 1992 and grant a rehearing thereof, the prayer of the said petition is denied.

A Copy,

Teste:

Clerk

APPENDIX D

42 U.S.C. § 1395dd (1988).

§ 1395dd. Examination and treatment for emergency medical conditions and women in active labor (a) Medical screening requirement. In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title [42 U.S.C. §§ 1395 et seq.]) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (e)(1)) exists or to determine if the

individual is in active labor (within the meaning of subsection (e)(2)).

(b) Necessary stabilizing treatment for emergency medical conditions and active labor.

(1) In general. If any individual (whether or not eligible for benefits under this title [42 U.S.C. §§ 1395 et seq.]) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either----

(A) within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical

condition or to provide for treatment of the labor, or

(B) for transfer of the individual to another medical facility in accordance with subsection (c).

(2) Refusal to consent to treatment. A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a person acting on the individual's behalf) refuses to consent to the examination or treatment.

(3) Refusal to consent to transfer. A hospital is deemed to meet the requirement of paragraph (1)

with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a person acting on the individual's behalf) refuses to consent to the transfer.

(c) **Restricting transfers until patient stabilized.**

(1) Rule. If a patient at a hospital has an emergency medical condition which has not been stabilized (within the meaning of subsection (e)(4)(B)) or is in active labor, the hospital may not transfer the patient unless---

(A)(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

(ii) a physician (within the meaning of section 1861(r)(1) [42 U.S.C. § 1395x(r)(1)]), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's

medical condition from effecting the transfer; and

(B) the transfer is an appropriate transfer (within the meaning of paragraph (2)) to that facility.

(2) Appropriate transfer. An appropriate transfer to a medical facility is a transfer---

(A) in which the receiving facility--

(i) has available space and qualified personnel for the treatment of the patient, and

(ii) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

(B) in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

(C) in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

(D) which meets such other requirements as the Secretary may

find necessary in the interest of the health and safety of patients transferred.

(d) **Enforcement.** (1) As requirement of medicare provider agreement. If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to ---

(A) termination of its provider agreement under this title [42 U.S.C. §§ 1395 et seq.] in accordance with section 1866(b) [42 U.S.C. § 1395 cc(b)], or

(B) at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

(2) Civil monetary penalties. (A) A participating hospital that knowingly violates a requirement of this section is subject to a civil money penalty of not more than $50,000 for each such violation. The provisions of section 1128A [42 U.S.C. § 1320a-7a] (other than subsections (a) and (b)) shall apply to civil money penalty under this subparagraph in the same manner as such provisions apply with respect to a penalty or proceeding under section 1128A(a) [42 U.S.C. § 1320a-7a(a)].

(B) The responsible physician in a participating hospital with respect to the hospital's violation of a requirement of this subsection is subject to the sanctions described in section 1842(j)(2) [42 U.S.C. § 1395u(j)(2)], except that, for purposes of

this subparagraph, the civil money penalty with respect to each violation may not exceed $50,000, rather than $2,000.

(C) As used in this paragraph, the term "responsible physician" means, with respect to a hospital's violation of a requirement of this section, a physician who---

(i) is employed by, or under contract with, the participating hospital, and

(ii) acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the

individual, or transfers of the individual, with respect to which the violation occurred.

(3) Civil enforcement.

(A) Personal harm. Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(B) Financial loss to other medical facility. Any medical facility that suffers a financial loss as a direct result of a participating hospital's violation

of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

(C) Limitations on actions. No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

(e) **Definitions.** In this section:

(1) The term "emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate

medical attention could reasonably be expected to result in---

(A) placing the patient's health in serious jeopardy,

(B) serious impairment to bodily functions, or

(C) serious dysfunction of any bodily organ or part.

(2) The term "active labor" means labor at a time at which---

(A) delivery is imminent,

(B) there is inadequate time to effect safe transfer to another hospital prior to delivery, or

(C) a transfer may pose a threat of the health and safety of the patient or the unborn child.

(3) The term "participating hospital" means hospital that has entered into a provider agreement under section 1866 [42 U.S.C. § 1395cc].

(4)(A) The term "to stabilize" means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

(B) The term "stabilized" means, with respect to an emergency medical condition, that no material

deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

(5) The term "transfer" means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such a movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

(f) **Preemption.** The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

Va. Code Ann. § 8.01-581.2
(Repl. Vol. 1992)

§ 8.01-581.2. **Notice of claim for medical malpractice required; request for review by medical malpractice review panel; rescission of request; determination on request.** -- A. No action may be brought for malpractice against a health care provider unless the claimant notifies the health care provider in writing by registered or certified mail prior to the commencing the action. The written notification shall include the time of the alleged malpractice and a reasonable description of the act or acts of malpractice. The claimant or health care provider may within sixty days of

such notification file a written request for a review by a medical malpractice review panel established as provided in § 8.01-581.3. The request for review shall be mailed to the Chief Justice of the Supreme Court of Virginia. Upon receipt of such request, the Chief Justice shall designate one sitting or one retired circuit court judge to act as chairman of the panel and shall select the other panel members as provided in § 8.01-581.3:1. No actions based on alleged malpractice shall be brought within ninety days of the notification by the claimant to the health care provider and if a panel is requested within the period of review by the medical review panel.

B. Whenever the requesting party rescinds a request for review by a medical malpractice review panel, notice of such rescission shall be given to counsel for the opposing party at the time notice is given to the Chief Justice of the Supreme Court.

C. Notice of the determination of the Chief Justice on a request for review shall be given to counsel for both parties.

D. If a claim arising out of the same incident is asserted against more than one health care provider, the notice of claim shall name all of them and shall be filed with all of them. Any health care provider so named shall have the

right to request a panel and, in that event, shall mail copies of its request to the other health care providers named in the notice of claim as well as to the claimant and his counsel of record. When a request for a medical review panel is made by any party, a single panel shall be designated and all health care providers against whom a claim is asserted shall be subject to the jurisdiction of such panel. The provisions of this subsection shall not prohibit the addition of parties pursuant to § 8.01-581.2:1.

APPENDIX E

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Health Care Financing
Administration

Regional Office VI
1200 Main Tower Building
Dallas, Texas 75202

January 29, 1992

REGIONAL HEALTH STANDARDS AND QUALITY
LETTER NO. 92-08

TO: All State Survey Agencies (Action)
All State XIX Single State Agencies
(Information)

SUBJECT: Enforcement of the Anti-Dumping Provisions of Section 1867 of the Social Security Act (the Act)

This statement sets forth the anti-dumping enforcement procedures as they apply to State Survey Agencies (SAs), based upon

information provided to us by the Health Standards and Quality Bureau. Our purpose is to outline the anti-dumping provisions in the statute and not to establish rules, subject to the notice and comment provisions of the Administrative Procedures Act.

These instructions may be modified, as necessary, in accordance with the forthcoming final regulations. In addition, attached are copies of section 1867 and pertinent parts of section 1866

and section 1154, as well as physician review forms.

Sincerely,

Kenneth C. Schneider, M.D.,
Associate Regional
Administrator for Health
Standards and Quality

ENFORCEMENT PROCEDURES

A. SCOPE

The underlying concept of section 1867 of the Act is "equal treatment." With the passage of section 1867 in 1986, Congress intended that all individuals would have equal access to emergency treatment in hospitals having Medicare provider agreements. They intended this even if the individual could not pay for the treatment, did not have medical insurance, and was not enrolled in Medicare or eligible for Medicaid.

Accordingly, when an individual comes to a hospital with an emergency department and

seeks treatment, he or she must be screened to determine if an emergency medical condition exists. If so, the hospital must provide, within its staff and facilities available, for further medical examination and treatment to stabilize the medical condition, or for transfer of the individual to another medical facility in accordance with section 1867(c)(2).

All provisions of the anti-dumping statute, including the documentation and transfer requirements, are applicable once an individual with an emergency medical condition or a woman in labor presents him or herself and requests services at a

Medicare participating hospital that has an emergency department. The anti-dumping requirements continue to apply until the individual is properly examined, treated, stabilized and, if appropriate, either admitted to the hospital, discharged, or properly transferred, unless the individual or his/her representative refuses any of those services. This does not mean that the anti-dumping provisions apply to all hospital transfers. Once an individual's emergency medical condition is stabilized as defined under section 1867(e)(3) the hospital has met its obligations under this statute and it no longer is required to comply with the other anti-dumping documentation or

transfer requirements. However, until the individual is stabilized, the hospital is obligated to comply with all provisions of the anti-dumping statute. In such a case, the documentation and transfer requirements would apply without regard to the hospital unit that initiates a transfer or to where the patient is transferred.

B. SECTION 1866 OBLIGATIONS

Section 1866 includes four (4) requirements related to section 1867. Hospitals must comply with these requirements in order to participate in the Medicare and Medicaid programs.

1. Section 1866(a)(1)(I)(i) - requires a hospital to have and enforce policies to ensure compliance with the requirements of section 1867.

2. Section 1866(a)(1)(I)(ii) - requires a hospital to maintain medical and other records related to individuals transferred (including discharged) to or from the hospital for a period of 5 years from the date of the transfer.

3. Section 1866(a)(1)(I)(iii) - requires a hospital to maintain a list of physicians who are on call to provide treatment necessary to stabilize an individual with an emergency medical condition.

4. Section 1866(a)(1)(N)(iii) and (iv) - requires a hospital to post conspicuously a sign(s) specifying the rights of individuals, under section 1867, with respect to examination and treatment for emergency medical conditions and women in labor and to indicate whether or not the hospital participates in the Medicaid program.

C. SECTION 1867 OBLIGATIONS

Section 1867 places six (6) requirements on hospitals that have an emergency department. Hospitals must comply with these requirements to participate in the Medicare and Medicaid programs.

1. Section 1867(a) - Screening - requires a hospital to screen all individuals who come to the hospital and request an examination or treatment for a medical condition. The medical screening examination must be appropriate and within the hospital's capability, including ancillary services routinely available, to determine whether or not an emergency medical condition exists.

2. Section 1867(b) - Treatment - requires that once a hospital determines that the individual has an emergency medical condition, it must provide either further medical examination and such treatment as may be required to stabilize the medical condition, within the staff

and facilities available at the hospital, or transfer in accordance with the requirements of section 1867(c).

3.a. Section 1867(c)(1) - Transfer - prohibits a hospital from transferring an individual with an emergency medical condition which has not been stabilized unless (1) the individual (or legally responsible person acting on the individual's behalf) after being informed of the hospital's obligations under this section and of the risk of transfer, requests transfer, in writing, to another medical facility; or, (2) a physician has signed a certification that based on the information available at the time of transfer, the medical benefits reasonably

expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual and, in the case of labor, to the unborn child from effecting the transfer; or (3) if a physician is not physically present in the emergency department at the time the individual is transferred, a qualified medical person (as defined by the Secretary in regulations) has signed a certification, in consultation with a physician who subsequently signs the certification, stating that the medical benefits reasonably expected from the provision of appropriate medical treatment at another

medical facility outweigh the increased risks to the individual.

3.b. Section 1867(c)(2) - requires a hospital to effect an <u>appropriate</u> transfer if the individual has an emergency medical condition that has not been stabilized. The hospital may not transfer the individual unless the individual requests transfer or a physician certifies the medical necessity of the transfer.

To make an appropriate transfer the transferring hospital must (1) provide the medical treatment, within its capacity, which minimizes the risk to the individual; (2) send all pertinent medical records available, at the time of

transfer, to the receiving hospital; (3) effect the transfer through qualified personnel and transportation equipment, including necessary life support measures; and (4) obtain the consent of the receiving hospital.

NOTE: Once a physician determines and documents that an individual has been stabilized pursuant to section 1867(e)(3) of the Act, the anti-dumping statute does not impose any additional requirements on a transferring hospital that are not already required by other Federal, State or local laws. In such situations, once the hospital has complied with the examination,

treatment and stabilization requirements of the statute, it has met all of the anti-dumping statutory requirements.

4. Section 1867(g) - Nondiscrimination - prohibits a hospital with specialized capabilities or facilities (such as burn units, shock-trauma units, neonatal intensive care units) from refusing to accept an appropriate transfer of an individual who requires those specialized capabilities if the specialized hospital has the capacity to treat the individual.

5. Section 1867(h) - No delay in examination or treatment - prohibits a hospital from delaying a medical screening

examination or stabilizing treatment in order to inquire about an individual's method of payment or insurance status.

NOTE: Regardless of whether a hospital will be paid, it is obligated to provide the services specified in section 1867.

6. Section 1867(i) - Whistleblower protections - provides whistleblower protections to physicians who refuse to authorize the transfer of an individual who has not been stabilized. It also provides whistleblower protections to qualified medical personnel who refuse to authorize the transfer of an individual with an emergency medical condition, that has not been stabilized, and to any

hospital employee who reports a violation of section 1867.

D. DEFINITIONS

1. Capability - means the services a hospital provides (e.g., psychiatry, obstetrics, intensive care, trauma care).

2. Capacity - means the ability of the hospital to accommodate an individual in need of examination or treatment. Capacity encompasses such things as numbers and availability of qualified staff, beds and equipment.

3. Emergency medical condition - means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that

the absence of immediate medical attention could reasonably be expected to result in (1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (2) serious impairment to any bodily function, or (3) serious dysfunction of any bodily part.

- Psychiatric emergency - the statute provides a definition of an emergency medical condition; it does not provide a separate definition of a psychiatric emergency. For a psychiatric condition to be considered an emergency, it must meet the general requirements of an

emergency as defined above and in Section 1867(e)(I).

- Pregnant woman who is having contractions - has an emergency medical condition if there is an inadequate amount of time to effect a safe transfer to another hospital before delivery, or if the transfer may pose a threat to the health or safety of the woman or the unborn child. If the pregnant woman has an emergency medical condition, the hospital must either deliver the baby, including the placenta, or effect an appropriate transfer.

4. Labor - means the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta.

5. On-call physician list - means a list of physicians maintained by the hospital, as required by section 1866, who are available after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition.

6. Specialized capabilities or facilities - for the purpose of the non-discrimination provision of section 1867(g) means capabilities or facilities such as burn units, shock-trauma units, neonatal intensive care units, or (with

respect to rural areas) regional referral centers as identified by the Secretary in regulation.

7. Stabilize - means to provide such medical treatment necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result or occur during the transfer or that a woman in labor has delivered, including the placenta.

8. Transfer - means the movement, including the discharge, of an individual outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does

not include such a movement of an individual who has (A) been declared dead, or (B) leaves the facility without the permission of any such person.

* * * * *

G. Evaluation of the applicability of section 1867

1. 42 CFR section 482.12(f) - hospitals that have emergency departments are subject to section 1867 and the anti-dumping provisions of section 1866. Hospitals that do not have emergency departments must still have written policies and procedures for appraisal of emergencies, initial treatment,

and referral when appropriate, and must comply with the Conditions of Participation in this regard.

* * * * *

APPENDIX F

Medicare Requirements for Emergency Services and Transfers

Special Member Briefing

October 1990

American Hospital Association

* * * * * *

Purpose of the Guide

The OBRA 89 requirements took effect on July 1, 1990, even though no final regulations have been issued by HCFA to govern implementation. HCFA has issued instructions about the posting of signs, but otherwise has not developed any guidelines to explain new terms or ambiguous provisions of the statute. Consequently, hospitals must base their compliance action on the statute. AHA has been working with many member hospitals on revising emergency department procedures to comply with the spirit as well as the letter of the law. This guide, which is based on the most frequently asked questions, grew out of our efforts to clarify the meaning of the new law and to help hospitals operationalize and

demonstrate their compliance with the requirements.

The information contained in this guide does not constitute legal advice. These interpretations are based on a close reading of the law by AHA staff, without benefit of HCFA final regulations. Each hospital should consult with legal counsel when assessing its compliance with the new requirements. While the interpretations offered here represent a reasonable approach to implementing the new requirements, they may not match policy decisions that emerge in subsequent regulations or through hospital enforcement actions.

In an effort to answer some of the more frequently asked questions about interpretation of the new provisions, AHA sent a letter to Gail Wilensky, Ph.D., Administrator of HCFA, requesting clarification of a number of issues. AHA received a response to its inquiry on September 15, 1990, basically confirming the interpretations outlined in the July 9 letter and elaborated on in this briefing. Several important issues nevertheless remain unresolved. Copies of both AHA's letter to Dr. Wilensky and her recent response (Reference No. 90-30) are available from the AHA Resource Center at 312/280-6263.

* * * * *

Do the transfer protocols have to be observed for hospital inpatients?

No. Taken together, these requirements describe a series of steps for the identification and treatment of individuals who come to a hospital's emergency department seeking care for an emergency medical condition. Many hospitals have questioned whether the requirements for transfer in this law would apply to hospital inpatients who develop emergency medical conditions and may need to be transferred to another facility. The logic of the law as just described suggests that it does not pertain to the transfer of hospital inpatients. This does not preclude the possibility that subsequent court judgments may apply the transfer

protocols in cases involving inpatients and some hospitals may wish to adopt this broader interpretation pending further judicial action.

* * * * * *

APPENDIX G

American Hospital Association

Capital Place, Building #3
50 F Street N.W.
Suite 1100
Washington, D.C. 20001
Telephone (202) 638-1100
Fax No. (202) 626-1345

HAND DELIVERED

July 9, 1990

Gail R. Wilensky, Ph.D.
Administrator
Health Care Financing Administration
200 Independence Avenue, S.W. -
Room 309-G
Washington, D.C. 20201

Re: Implementation of OBRA 1989 Revisions to Patient Transfer Requirements

Dear Dr. Wilensky:

As you know, the Omnibus Budget Reconciliation Act of 1989 (OBRA) amended the requirements for Medicare-

participating hospitals offering emergency services. Hospitals now must:

- post signs in their emergency rooms explaining their responsibilities in emergencies;

- make reasonable efforts to obtain from patients written informed consents to transfer or refusals of treatment;

- not delay a medical screening examination or stabilizing treatment in order to inquire about payment or insurance status;

- maintain a roster of on-call physicians to furnish stabilizing treatment in the emergency room;

- assure that a physician certifies transfer decisions and identifies the attendant risks;

- accept transfers from other hospitals, if they have specialized capabilities and capacity.

These new requirements took effect on July 1, 1990, in spite of the fact that regulations have not yet been issued to implement them. In fact, no regulations have been issued to date to implement the original requirements contained in the

Consolidated Omnibus Budget Reconciliation Act of 1985.

Instructions concerning the sign requirements in the OBRA provisions have been developed and circulated by HCFA, with sample language for the signs to be posted in emergency rooms. However, we understand that no other regulations or instructions to clarify hospital obligations under the new law are forthcoming. In the absence of any guidance from HCFA, each hospital must develop policies and procedures based on its own interpretation of the law.

Although the basic structure of the statutory provisions appears generally consistent with the standard hospital

protocol for handling emergency patients, several questions have arisen about the meaning of key provisions and the extent of new obligations actually imposed on hospitals under the new law. Hospitals are therefore uncertain about whether they have to restructure their emergency room policies and procedures to assure their compliance with the new requirements. In particular, our members have raised questions abut the following requirements:

- to treat emergency patients;

- to provide a medical screening examination "within the capability of the emergency department";

- to provide "stabilizing treatment" to individuals with emergency medical conditions;

- not to delay screening or stabilizing treatment to gather information about the individual's insurance status;

- to maintain a roster of on-call physicians;

- for on-call physicians to appear within a "reasonable period of time" to stabilize an individual with an emergency medical condition; and

- for specialized facilities to accept transfers.

In the following sections, we raise our members' questions about each of these issues and suggest what we believe the plain language of the statute requires. We believe that these are sound interpretations and, in the absence of regulations, offer reasonable guidance to our members on how to ensure compliance with the statute. For this reason, we would appreciate your reactions to this advice and, in particular, any problems that you foresee if our members follow it.

Scope of Required Treatment Under Sec. 1867

As we understand the statute, hospitals have the following obligations toward any individual who comes to the emergency room. A hospital with an emergency department must provide a medical screening examination to determine whether an emergency medical condition exists. If the individual has an emergency medical condition, a hospital must either stabilize the individual's condition or provide for an "appropriate" transfer. Transfer of an unstable individual can be undertaken if the individual requests the transfer in writing after being informed of the hospital's obligations and of the risks of transfer, or if a physician, or qualified medical person in consultation

with a physician, concludes that the medical benefits of treatment at another facility outweigh the increased risks of transfer to that facility.

The provisions of Sec. 1867 pertain only to the treatment of emergencies and, in particular, the protocol for handling transfers. The Medicare statute does not address the extent of a hospital's obligation to treat individuals beyond emergency situations. Those obligations are established through case law and other programmatic regulations, like those for the Hill-Burton program, which oblige hospitals to provide services to individuals who cannot afford to pay for their care.

Medical Screening Examination

Section 1867(a) of the Social Security Act (the Act) requires hospitals to furnish a medical screening examination "within the capability of the hospital's emergency department." The statute specifies that "the capability of the hospital's emergency department" includes "ancillary services routinely available to the emergency department." Hospitals seek clarification, however, on how extensive this medical screening examination must be.

According to the statute, the purpose of the medical screening examination is to determine whether an individual who comes to the emergency department has an

emergency medical condition. Therefore, the required examination is that which is necessary to determine whether an emergency exists. A simple examination by a triage nurse would be sufficient in some cases, whereas in other cases a more extensive medical evaluation would be necessary, including diagnostic tests, depending on the patient's condition.

In the context of the medical screening examination, we believe the plain meaning of the phrase "within the capability of the hospital's emergency department" encompasses only those services that are available to any emergency patient at the time the emergency department visit occurs. This would mean, first, that all individuals in the emergency room would

have access to the same services. But it also means that hospitals retain the right to define the scope of services available to the emergency department. We do not believe that these provisions require hospitals to expand their emergency department capabilities beyond what they generally (or "routinely") make available to all emergency patients through the emergency room. Some services cannot be made available through the emergency room or are available only during certain hours because staff are not available at all times. For example, computerized tomography or complex radiology procedures may be available only when a neurologist or radiologist is available to administer the procedure.

Providing Stabilizing and Risk Minimizing Treatment

Section 1867(b)(1)(A) now requires a hospital to provide further medical examination and "such treatment as may be required to stabilize" an emergency medical condition "within the staff and facilities available at the hospital." To "stabilize" is defined in Sec. 1867(a)(3)(B) to mean that no "material deterioration of the condition" is likely, "within reasonable medical probability," to result from or occur during a transfer.

How much treatment is required to stabilize an individual's emergency medical condition? The answer depends upon the medical condition involved. For example, a woman in labor is defined as

having an emergency medical condition if there is inadequate time to safely transfer, or the transfer poses a threat to the woman or unborn child's health. In such a case, "stabilization" would require delivery of the baby. Stabilization of other emergency medical conditions would require hospitals to mitigate the emergency, but not necessarily to eliminate the underlying clinical condition. For example, a patient with chest pains who is determined to have a possibly fatal arrythmia could be stabilized with medications sufficient to allow further care of the underlying heart disease that led to the emergency. In some cases, as with chronic conditions, stabilization of the emergency may represent the full

extent of treatment. For example, an emergency asthma attack may be fully treated with drugs which open the airway.

If the decision is made to transfer an unstabilized patient, the hospital must provide "medical treatment within its capacity to minimize the risks." For example, a trauma victim with serious soft tissue damage and an open bone fracture of the leg might be injured beyond the capabilities of the average emergency room physician. The emergency room physician in this case might minimize the risk of transfer by cleaning the wound, stanching the bleeding, securing the leg, and making the individual as comfortable as possible for transfer to an institution where an

orthopedist would be available to set the leg and perform any necessary surgery.

Many providers have expressed particular concern over obstetric emergencies. We feel that it is important to note that the statute distinguishes between women in labor who have an emergency medical condition, and those who do not. The law does not require delivery with regard to every woman in labor presenting at the emergency department. Rather, delivery must occur if an emergency condition exists, which, as discussed above, is defined as where there is inadequate time to transfer or transfer poses a health risk.

Hospitals have also asked how these concepts would apply to psychiatric emergencies. While not specifically addressed in the statute, the notion of "stabilization" can be applied to psychiatric conditions. "Emergency medical condition" is defined in Sec. 1867(a) in relation to physiological danger only. In the context of psychiatric emergencies, an emergency condition exists when an individual presents an immediate physical threat to himself or others. Stabilizing treatment for these patients would entail those actions necessary to remove that threat, albeit temporarily, so that the danger which constitutes the emergency is removed, even though the underlying

psychiatric problem may not be eliminated.

Maintaining a List of On-Call Physicians

Section 1866(a)(1)(I)(iii) requires hospitals to maintain a roster or schedule of physicians who are on call for duty after the initial examination to provide stabilizing treatment. Questions have been raised about whether this provision requires all physicians to provide on-call services to hospital emergency departments or requires hospital emergency departments to expand on-call coverage to include all medical services available to the hospital around the clock.

We interpret this provision to mean that a hospital must ensure 24-hour coverage of the emergency room by at least one physician through an on-call roster of the medical staff, but it does not require that every physician be on-call. This would be consistent with Joint Commission standards for emergency departments (AMH Standard BR.1.4.3). We believe that hospitals are required to stabilize individuals using the resources available when the individual comes to the emergency department and that the hospital retains the right to define the scope of services that would generally be offered through its emergency room, which will not necessarily involve all medical specialties represented on the entire medical staff.

The requirement for maintaining a list of on-call physicians to provide stabilizing treatment does not mean that every physician on the medical staff must be available on-call for emergency room duty or that all services must be accessible around the clock. Some specialized services cannot be staffed around the clock. In some areas, a small hospital may have a single orthopedic surgeon or other specialist whom it shares with other hospitals, limiting the basis on which it can offer the service. If an individual's condition requires treatment exceeding the level of services immediately available through the emergency department, the emergency department physician or other qualified medical person would have to take this

into account in making a decision as to whether to treat or transfer.

Failure to appear within a "reasonable period of time"

Section 1867(d)(2)(C) offers liability protection to a physician who authorizes a transfer after determining that the benefits of transfer exceed the risks, when an on-call physician fails or refuses to appear "within a reasonable period of time." The on-call physician who failed or refused to appear and the hospital could, however, be liable. This raises the question of what constitutes a reasonable period of time in which to appear for duty to stabilize individuals with an emergency medical condition.

We believe that "reasonable period of time" must be understood both in terms of the time within which an on-call physician may be expected to arrive at the hospital and the time within which the treating physician must make a transfer decision even when an on-call physician is en route. What constitutes a reasonable period of time therefore depends upon the nature of each individual's emergency condition. It would therefore be inappropriate to establish an arbitrary time within which an on-call physician would be expected to appear.

We believe further that there are circumstances when it would be inappropriate to impose a penalty for a

physician's failure to appear within a "reasonable period of time." Legitimate reasons that an on-call physician might fail to appear include the urgent need to perform another medical procedure or unavoidable traffic delays that prevent prompt arrival at the facility. Such legitimate reasons for failing to appear should constitute appropriate grounds for exemption from liability, and penalties should apply to neither the hospital nor the on-call physician when the physician is contacted but unable to appear.

Capacity of Specialized Receiving Facility to Treat Transfers

According to Sec. 1867(g), a hospital with specialized capabilities or facilities (for example, a shock/trauma

unit, burn unit, or cardiac intensive care unit) cannot refuse to accept an appropriate transfer of an individual needing such specialized treatment if the hospital has the capacity to treat the individual.

Several hospitals have questioned the meaning of "capacity" to treat. We believe that a hospital would be obligated to accept a transfer patient who needs its specialized services or facilities if it has the immediate ability to treat the individual, but not if personnel are unavailable at the time transfer is requested, equipment is in use, or facilities are filled to capacity. We believe the statute obligates hospitals to accept patients

needing its specialized services or facilities only to the extent that they need those specialized services and only to the extent that there is room in the specialized unit to treat them. Receiving facilities are obligated to treat the emergency only as long as the specialized facilities or capabilities are needed.

Inquiries about Insurance Status During Emergencies

Section 1867(h) prohibits a hospital from delaying the medical screening examination or any necessary stabilizing treatment to determine an individual's insurance status or method of payment. At what point, then, can the hospital gather information from the individual,

including information about the individual's insurance status?

The statute is clear on this point, if not precise. Hospitals may inquire about an individual's insurance status at any time as long as the initial screening and stabilizing treatment are not delayed in order to obtain the information. The statute would prevent the delay of not only the screening examination, but also any stabilizing treatment required.

We do not believe this section should be construed as prohibiting the collection of any financial information, particularly from the family, while care is being provided to the individual or

while a patient is in a queue for diagnostic tests.

Conclusion

AHA appreciates the seriousness of the patient transfer requirements. The statute is designed to provide safeguards against the very infrequent medically inappropriate transfer, and not to prohibit or even inhibit appropriate transfers. We believe that our suggestions represent a sensible interpretation of the new requirements and that for most hospitals, compliance should require no radical changes in the way they currently treat individuals with emergency medical conditions.

Aggressive enforcement of the original patient protection provisions in some regions, combined with the lack of guidance on the meaning of the new requirements, has raised the level of anxiety among hospitals and created some confusion about what hospitals should be doing to implement the new law. We need some indication that HCFA agrees with our interpretations of the new provisions so that our members can be assured that their policies and procedures comply with the law. We also urge HCFA to reflect these interpretations in its own regulations implementing the patient transfer requirements and hope that those regulations will be forthcoming in the near future.

If you have additional questions about the issues outlined above, please contact Thomas Granatir (312/280-6183) in our Chicago office or Gaelynn DeMartino (202/636-2361) in our Washington office.

Sincerely

Paul C. Rettig
Executive Vice-President

APPENDIX H

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Health Care Financing Administration

September 17, 1990

The Administrator
Washington, D.C. 20201

Mr. Paul C. Rettig
Executive Vice-President
American Hospital Association
Capitol Place, Building #3
50 F Street, N.W., Suite 1100
Washington, D.C. 20001

Dear ~~Mr. Rettig~~ Paul:

I am responding to your letter requesting written verification from the Health Care Financing Administration (HCFA) that your interpretations of the statute's anti-dumping provisions, as

amended by the Omnibus Budget Reconciliation Act of 1989 (OBRA 89), are correct and can be used to offer reasonable guidance to your member hospitals on how to ensure compliance.

As you know, a proposed rule with comment period that would implement section 1867 of the Social Security Act (the Act) was published June 16, 1988, in the Federal Register at 53 FR 22513. After receiving extensive public comments, we developed a final regulation. However, Congress passed OBRA 89, which amended and added new requirements to the anti-dumping provisions. We have, therefore, been rewriting the final regulation to

incorporate these new statutory requirements. We expect to publish a final regulation, with the opportunity for further public comment, within the next few months.

I am sure you understand that, as with all Federal regulations, instructions and guidelines, we cannot develop and write policies which explicitly address all possible situations that can arise. We can only develop and write policies and guidelines which will set overall, general rules for the application of the statutory provisions. They are used by Medicare participating providers and Federal surveyors to analyze and judge medical

emergency situations in accordance with the intent of Congress which, in this case, is to protect the health and safety of emergency medical patients and women in labor. I can state, though, that your basic understanding of the intent and application of these provisions is correct. In this letter, I will try to give you as much guidance as I can at this time concerning the issues you have raised. We believe as you do that hospitals which have been showing good faith efforts in handling emergency situations and operating under standard hospital protocols will not find it necessary to make significant changes in

their emergency room policies and procedures to comply with the anti-dumping requirements.

I want to preface my replies to your questions by indicating that each individual situation will have to be reviewed. Our assessments will be based upon all the information existing at the time of the emergency situation within the overall guidelines of the final anti-dumping regulation. Except for the specific items cited below, we concur with your basic understanding of the application of the statute's anti-dumping provisions. Please keep in mind, though, that the final regulation specifying the

requirements must still undergo final review and clearance. There may be changes in our interpretations of these requirements as a result of that review.

Your understanding of the scope of required treatment under section 1867 of the Act is correct. However, we would also note the statutory requirement for physicians or qualified medical personnel to sign a certification to the effect that the reason for the transfer outweighs the increased risks of transfer to another facility.

Your interpretation of section 1867(a) of the Act regarding medical screening examination requirements, while

written to stress the statutory limits of a hospital's obligations, is correct. The key is the requirement that services be available, including ancillary services, that would be available generally to the hospital's emergency patients. While it is true that some sophisticated services may not be available at all hours, it is also true that the inability to use such services may necessitate further observation or admission of a patient who requires such services for the diagnosis or treatment of his or her emergency medical condition or labor.

We agree with your general interpretations of sections 1867(b)(1)(A)

and 1867(c) of the Act regarding stabilizing and risk minimizing treatment requirements, including your discussion of psychiatric emergencies.

Our response to the issue regarding section 1866(a)(1)(I)(iii) of the Act regarding on-call physicians lists is similar to the one we previously gave concerning medical screening examination requirements. We believe that during a hospital's normal operating hours all medical specialties represented on the medical staff should be available for emergency services. However, it would not be reasonable to require this type of coverage when ancillary departments are

ordinarily not in operation, such as Sundays and holidays.

I hope this information will assist your member hospitls to better understand and comply with the anti-dumping statutory requirements and, thereby, reduce confusion and anxiety.

Sincerely,

Gail R. Wilensky, Ph.D.
Administrator

APPENDIX I

DEPARTMENT OF HEALTH
AND HUMAN SERVICES

Health Care Financing Administration

Refer to: EQA-812

6325 Security Boulevard
Baltimore, MD 21207

August 14, 1990

Mr. R. Mark Hodges
Wise, Carter, Child and Caraway
Professional Association
600 Heritage Building, P.O. Box 651
Jackson, Mississippi 39205

Dear Mr. Hodges:

I am responding to your letter requesting a written statement from the Health Care Financing Administration (HCFA) as to whether the provisions of section 6018, Hospital Anti-Dumping Provisions, of the Omnibus Budget Reconciliation Act of 1989 (OBRA '89), Public Law 101-239, apply

only to hospitals with emergency departments or whether they apply to all provider hospitals. You also asked that if the section 6018 provisions apply to all hospitals, do they thereby make the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA '85), Public Law 99-272, the original anti-dumping statute, also apply to all hospitals, not just hospitals with emergency departments.

As I advised you during our telephone conversation, it is HCFA's position that all provisions of the anti-dumping statutes, including all COBRA '85 and OBRA '89 provisions, do not apply to all Medicare participating hospitals. They only apply to Medicare participating

hospitals with emergency departments. As indicated in the very first sentence of section 1867 of the Social Security Act, as established by COBRA '85, the anti-dumping requirements apply, "In the case of a hospital that has a hospital emergency department . . ." We base our position that section 6018 of OBRA '89 does not expunge the "hospital emergency department" language of section 1867 upon the language of subsection 6018(a)(1)(I)(i) which directs Medicare participating hospitals "to adopt and enforce a policy to ensure compliance with the requirements of section 1867."

We read this language to mean that section 6018, and all other OBRA '89 provisions, extend the original COBRA '85

anti-dumping requirements, including the requirements which specify to which Medicare providers the provisions apply.

Sincerely yours,

Thomas E. Hoyer, Jr.
Director, Division of Provider
Services Coverage Policy
Office of Coverage
and Eligibility Policy
Bureau of Policy Development

Supreme Court, U.S.
FILED
OCT 2 1992
OFFICE OF THE CLERK

No. 92-421

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1992

RICHMOND MEMORIAL HOSPITAL,

Petitioner,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

Petition for Writ of Certiorari to the Supreme Court of Virginia

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

Edward W. Taylor
Counsel of Record
Taylor & Schockemoehl, P.C.
601 North Courthouse Road
Richmond, Virginia 23236
(804) 794-7600
Counsel for Respondent

QUESTIONS PRESENTED

1. Whether or not a decision of a state's highest court which overrules a trial court's order sustaining a demurrer and remands for trial on the merits of a case involving an issue of federal law is a final judgment which may invoke the jurisdiction of this Court under 28 USC §1257(a)?

2. Whether or not the Virginia Supreme Court's unanimous decision that the transfer from a hospital of a woman suffering from an emergency medical condition and in labor constitutes patient dumping in violation of 42 U.S.C. §1395dd presents a substantially important federal question which should be settled by this Court at this time when the statute is plain and unambiguous on its face, when no state supreme court except Virginia has yet decided the precise issue raised, when the federal

circuits are not in conflict and Virginia's holding is not in conflict with any decision of this Court?

3. Whether or not a female patient with pre-term rupture of membranes must be admitted to a hospital's emergency room and discharged from the emergency room before she is able to invoke the protection of the patient dumping law, or whether or not a pregnant patient has the protection of the anti-dumping provisions of 42 U.S.C. §1395dd if she is admitted directly to the hospital's Labor and Delivery Suite and is later transferred from Labor and Delivery to another hospital while suffering an emergency medical condition and in labor?

4. Whether or not the COBRA federal cause of action for patient dumping based on strict liability preempts Virginia's medical malpractice Act which requires prior written notice before a medical malpractice

suit can be filed?

RULE 29.1 LIST

The parties are listed correctly in the Appellant's List of Parties. The Appellant states it is a "non-profit" corporation. Richmond Memorial Hospital is exempt from taxation under 26 U.S.C. §501(c)(3) (Internal Revenue Code of 1954), however, it does make a profit[1]. Health Corporation of Virginia, its parent company, is reported to be a profit making entity[2].

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[1] 1992 Annual Report, Volume II, The Data Resource, Virginia Health Services Cost Review Council, p. 145.

[2] See Beverly Orndorff, Hospitals profiting from spinoff firms, Richmond Times Dispatch, December 3, 1990, page A-2, in which it is reported that Health Corporation of Virginia has some fourteen affiliate companies, five of which are for profit operations including a tax entity enterprise, a pharmacy, a collection agency, condominiums, and a retirement community development and management activity.

TABLE OF CONTENTS

QUESTIONS PRESENTED i

RULE 29.1 LIST iii

OPINIONS BELOW 2

JURISDICTION 2

STATUTES INVOLVED 2

STATEMENT OF FACTS 3

REASONS WHY THE PETITION SHOULD BE DENIED 10

I. THE JUDGMENT OF THE VIRGINIA SUPREME COURT OVERRULING A DEMURRER IS NOT A REVIEWABLE FINAL ORDER UNDER 28 U.S.C. §1257(A). 10

A. In civil litigation, the judgment of the highest state court relating to a demurrer or motion to dismiss a complaint is final only if the case is thereby disposed of conclusively. 10

B. Jurisdiction should not be exercised in piecemeal proceedings. This Court does not render advisory opinions. Smith is not in conflict with any decision of this Court, any other state court or any court of appeals. 14

C. The Petitioner's reliance on the fourth exception of Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 is misplaced. No federal policy will be seriously eroded if the Court refuses to immediately review this state court decision. 19

ARGUMENT 25

II. THE ACT DOES NOT REQUIRE AS A PREREQUISITE FOR COVERAGE THAT A PATIENT FIRST PRESENT TO THE HOSPITAL'S EMERGENCY ROOM OR THAT THE DISCHARGE BE FROM THE EMERGENCY ROOM. IT COVERS ANY PATIENT WHO COMES TO A HOSPITAL OR IS A PATIENT

AT A HOSPITAL. 26

III. MS. SMITH'S PRESENTATION TO THE EMERGENCY ROOM IS MOOT BECAUSE THE HOSPITAL HAD A POLICY THAT PATIENTS IN LABOR GO DIRECTLY TO LABOR AND DELIVERY. 33

IV. ADMINISTRATIVE LETTERS AND HCFA INTERPRETATIVE GUIDELINES WHICH DO NOT HAVE THE FORCE AND EFFECT OF LAW ARE NOT MADE PURSUANT TO DELEGATED AUTHORITY AND ARE NOT BINDING ON COURTS. SUCH GUIDELINES WERE NOT MADE A PART OF THE TRIAL RECORD OR THE APPENDIX TO THE VIRGINIA SUPREME COURT 35

V. THE ACT (42 U.S.C. §1395DD) IS PLAIN ON ITS FACE AND VIRGINIA'S INTERPRETATION OF THE WORDS OF THE STATUTE DOES NOT SUBVERT THE PURPOSE OF THE

LEGISLATION OR LEAD TO AN ABSURD RESULT. 44

A. While the Act is broader than any or all members of Congress were cognizant of, it is not the place of courts to rewrite a statute which is plain on its face to conform with its notion of efficacy or rationality. 45

B. Whether or not a patient has insurance or is able to pay for his hospitalization is irrelevant to COBRA coverage. 47

C. Further statements made in the Petition are irrelevant to this inquiry. 48

VI. COBRA WHICH CREATES A FEDERAL CAUSE OF ACTION BASED ON STRICT LIABILITY AS DISTINGUISHED FROM AN ACTION FOR MEDICAL MALPRACTICE PREEMPTS VIRGINIA'S REQUIREMENT OF PRIOR WRITTEN NOTICE APPLICABLE TO VIRGINIA

MEDICAL MALPRACTICE ACTIONS. 54

CONCLUSION 65

APPENDIX A

RICHMOND MEMORIAL HOSPITAL
RICHMOND, VIRGINIA
RULES AND REGULATIONS
DIVISION OF OB/GYN

. i

APPENDIX B

RICHMOND MEMORIAL HOSPITAL
RICHMOND, VIRGINIA
RULES AND REGULATIONS
DIVISION OF OB/GYN

. vii

APPENDIX C

Letter dated July 5, 1989 from HCFA to
Allen Tuten, Administrator
Lincoln General Hospital
Post Office Drawer 1368
Ruston, Louisiana 71273 xiii

APPENDIX D

(Excerpt of transcript in trial court made a part of Appendix of Virginia Supreme Court.) xix

TABLE OF AUTHORITIES

CASES:

Bostwick v. Brinkerhoff, 106 U.S. 3 (1882) 11

Brooker v. Desert Hospital Corp., 947 F.2d 412, 414 (9th Cir. 1991) 47

Burditt v. U.S. Department of Health and Human Services, 934 F.2d 1362, 1369 (5th Cir. 1991) . . . 48

Burroughs v. Turner Memorial Hospital, 762 F. Supp. 762, 842 (W.D. Ark. 1991) 46, 56

Chesapeake & Ohio Railway Co. of Ky., et. al., 226 U.S. 602 (1912) 13

Chevron U.S.A. Inc. v. Natural Resources Defense Council, 467 U.S. 837 (Pet. 48) 41

Clark v. Kansas City, 172 U.S. 334 (1899) 13

Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990) 18, 19, 45

Clinger, Administratrix, Etc. v. Chesapeake & Ohio Railway Co. of Ky., et. al., 226 U.S. 602 (1912) . . 13

Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 . . . 19

DeBerry v. Sherman Hospital Association, 741 F. Supp. 1302, 1307 (N.D. Ill. 1990) 46

Felder v. Casey, 487 U.S. 131, 138 (1988) 58

Garrison v. International Paper Co., 714 F.2d 757, 759 n. 2 (8th Cir. 1983) 56

Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991) 47

General Electric Co. v. Gilbert, 429 U.S. 125, 141 (1976) 42, 43

Goodyear Atomic Corp. v. Miller (Pet. at 14) 21

Holmberg v. Armbrecht, 327 U. . 392, 395 (1946) . 56

Lee by Wetzel v. Alleghany Regional Hosp. Corp., 778 F.Supp. 900, 902 (W.D. Va. 1991) 52

Louisiana Navigation Co. v Oyster Comm'n of Louisiana, 226 U.S. 99 (1912) 13,15

McCabe, Administratrix v. The Maysville & Big Sandy Railroad Company et. al., 226 U.S. 601 (1912) . . . 13

McIntyre v. Schick, M.D. et. al., 1992 WL 134713, Opinion June 16, 1992 28

Meagher v. Minnesota Thresher Mfg. Co., 145 U.S. 608 (1892) 12

Meyers, Trustee, Etc. v. Samuels, et. al., 223 U.S. 715 (1911) 13

Missouri v. Kansas Interurban Railway Company v. City of Olathe, Kansas, 222 U.S. 185 (1911) 12

Nichols v. The City of Clevland, 220 U.S. 602 (1910) 3

Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. at 1370 (cited by Petitioner at Pet. 24) 51

Pope v. Atlantic Coast Line R. Co., 345 U.S. 379, 382 (1953) 16

Southland Corp. v. Keating (Pet. at 15) 22

Stevison v. Enid Health Sys., Inc., 920 F.2d 710, 713 (10th Cir. 1990) 53

Susan M. Power v. The Arlington Hospital, 1992 WL 210588 (E.D. Va. August 28, 1992) 64

Thompson v. St. Anne's Hospital, 716 F. Supp. 8, 10 (N.D. Ill. 1989) 46

Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990) 18, 62

Toliver v. Culpepper Memorial Hosp., C.A. No. 90-0501-A, slip op. (E.D. Va. Au. 30, 1991) 64

Urie v. Thompson, 337 U.S. 163 (1949) 13

Werner v. Charleston, 151 U.S. 360 (1894) 12

STATUTES:

26 U.S.C. §501(c)(3) iii

28 U.S.C. §1257 23

28 U.S.C. §1257(a) 2, 11

28 USC §1257(a) i

42 U.S.C. §1395dd . . . . . i, ii, 9, 25, 39, 61

42 U.S.C. §1395dd (1988) 2

42 U.S.C. §1395dd(b)(1) 47

42 U.S.C. §1395dd(c)(1)(A)(ii) 50

42 U.S.C. §1395dd(e)(1)(C) 48

42 U.S.C. §1395dd(e)(5) 50, 63

42 U.S.C. §1395dd) 44

Va. Code Ann. §8.01-581.2(A). 53, 55

Va. Code Ann. §8.01-581.1 . . . . . 57, 63

Va. Code Ann. §8.01-581.2 (Repl. Vol. 1992) 2

Va. Code Ann. §8.01-581.20A. 56, 62

42 U.S.C. §1395dd (f) 54

42 U.S.C. §1395dd(c) 25, 26

26 U.S.C. §501(c)(3) iii

28 U.S.C. §1257(a) . . . . . i, 2, 10, 22

42 U.S.C. §1395dd . . . . . i, ii, 2, 8, 24, 37, 43, 56

42 U.S.C. §1395dd(b)(1) 46

42 U.S.C. §1395dd(c)(1)(A)(ii) 49

42 U.S.C. §1395dd(e)(1)(C) 46

42 U.S.C. §1395dd(e)(5) 48, 57

42 U.S.C. §1395dd(d)(3)(C) 54

RULES:

Sup. Ct. R. 10. 19

Sup. Ct. R. 10. 18

TREATISES:

Koch, 1 Administrative Law and Practice §3.4 . . . 37

IN THE SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1992

RICHMOND MEMORIAL HOSPITAL,

Petitioner,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF VIRGINIA

The Respondents, infant and mother, respectfully pray that this Court deny a writ of certiorari to review the judgment and opinion of the Supreme Court of Virginia, entered on April 17, 1992. The style of the civil action was TAJA SMITH, an infant, who sues by

and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually, v. RICHMOND MEMORIAL HOSPITAL, reported at 243 Va. 445.

OPINIONS BELOW

The opinions below are correctly cited on page 2 of Appellant's Petition.

JURISDICTION

Respondents maintain jurisdiction is improperly invoked under 28 U.S.C. §1257(a).

STATUTES INVOLVED

The statute involved in this case is 42 U.S.C. §1395dd (1988). Respondents maintain that Va. Code Ann. §8.01-581.2 (Repl. Vol. 1992) requiring prior Notice is inapplicable to this federal cause of action.

STATEMENT OF FACTS

The facts are reported by the Virginia Supreme

Court in its opinion (Pet. A-2-5, 243 Va. at 447-448) as follows:

> Connie Elizabeth Smith was admitted to Richmond Memorial Hospital (the Hospital) as a patient on July 18, 1988. Ms. Smith was approximately 33 weeks pregnant and had premature rupture of the uterine membranes. Ms. Smith remained at the Hospital until July 23, 1988.
>
> During the afternoon of July 22, 1988, Ms. Smith complained of abdominal cramping and vaginal leakage. The discharge had turned a greenish yellow color. In the afternoon and again at 10:00 p.m. she was given Nembutal, a hypnotic drug. By 10:00 p.m., Ms. Smith was complaining of irregular abdominal pain and contractions. By 10:30 p.m., her contractions were timed at five minute intervals. At 11:45 p.m., she was taken to the labor and delivery facilities of the Hospital. The vaginal discharge was now dark green in color. By midnight, the opening to the patient's uterus had dilated one centimeter, she had cold chills, and her temperature had dropped to 95.3 degrees Fahrenheit.
>
> At 1:00 a.m., the Hospital called a physician, who ordered that Ms. Smith be transferred to the Medical College of Virginia Hospital (MCV). The physician was not Ms. Smith's regular attending physician, and he gave the verbal transfer order without examining her. Following the transfer order, a nurse began trying to locate an ambulance service to transfer Ms. Smith to MCV. Two services refused, and one was not obtained until the Richmond Memorial Hospital

administrator agreed that the cost of the transfer could be billed to MCV. Connie Smith was taken from the Hospital at 2:10 p.m. and was admitted to MCV at approximately 2:30 p.m. on July 23, 1988.

A medical resident at MCV assessed Ms. Smith's condition to be "(1) prolonged premature rupture of the membranes, (2) pre-term labor at 34 weeks, (3) the Chorioamnionitis should be ruled out, and (4) that there was questionable meconium discharge." At 3:30 a.m., Ms. Smith signed a consent for a caesarean delivery, if necessary. Her contractions were one to five minutes apart at 4:20 a.m. She was taken "emergently" to the delivery room where the child, Taja Smith, was delivered by caesarean operation at approximately 9:48 a.m. Both mother and child suffered substantial injuries. Taja has cerebral palsy and is severely brain damaged.

Premature rupture of membranes seven weeks before a mother's due date is an emergency in and of itself.[3] Additionally, Ms. Smith had given birth

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[3] In Burditt v. U.S. Department of Health and Human Services, 934 F.2d 1362, 1372 (5th Cir. 1991), the court stated: "Every reasonable adult, let alone physician, understands that labor evolves to delivery...". When membranes rupture, the sac surrounding and protecting the baby is removed. The mother and baby become vulnerable to ascending bacteria and infection. At the first sign of infection and/or when the baby's lungs are determined to be mature, reasonable care

previously twice before by Caesarean operation due to cephalopelvic disproportion (head does not fit through the birth canal or labor is dysfunctional); and she had once delivered a still born baby. A Caesarean operation had been planned by the mother's obstetrician for approximately August 18, 1988. The mother had a high-risk pregnancy. She received very little treatment while hospitalized at Richmond Memorial during the five-day period.

On July 22, 1988, the mother became seriously ill. On July 23, 1988, when she alleges she was suffering from an emergency medical condition and was in labor, she was transferred from Richmond Memorial Hospital to MCV Hospital. The doctor who gave the transfer order had never before seen, examined, or heard of Connie Smith. The doctor never came to examine her

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requires prompt delivery.

before transfer; he gave the order to transfer her over the telephone.

The hospital suggests that the transfer was "made in the best interest of the patient" (Pet. 5) but the transfer may have been made because the doctor did not want to come to the hospital or because the hospital wanted to rid itself of a potential liability. The hospital had the capacity to perform Caesarean operations and had pediatricians on staff. Its policy was to transfer women with pregnancies of less than 32 weeks if medically possible but to keep and deliver them at Richmond Memorial if the pregnancy was greater than 32 weeks. (See App. B, Rules and Regulations Division of OB/GYN, Richmond Memorial Hospital, Conduct of Labor, ¶B). Connie Smith was approximately 34 weeks

by dates when transferred[4].

There was no certificate signed by a doctor weighing the benefits and risks of the transfer. There was no physician in the ambulance who could have performed a delivery. The fetal heart monitoring strip at Richmond Memorial was not sent with the mother to MCV Hospital. Respondents have alleged that the transfer was likely to, and did in fact, place the health of Connie Smith and her infant child in jeopardy. They have alleged that a material deterioration of her condition was likely to, and did in fact, result from the transfer. (Motion for Judgment, containing seventeen pages and seventy-one numbered paragraphs, ¶ 68(1), App. D). These are factual issues for a jury. No discovery has been conducted and no evidence has been

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[4] She was 32.5 weeks to 33 weeks on admission five days earlier than transfer. (Pet. B-3). The baby was 36 weeks mature at birth (Pet. B-4).

heard in this case.

Negligence was not pleaded and the sole count in the Motion for Judgment was for illegal patient dumping under 42 U.S.C. §1395dd (also referred to as COBRA). The trial court sustained the hospital's demurrer to the Motion for Judgment without leave to amend. On appeal to the Virginia Supreme Court, that portion of the trial court's opinion which held that prior written Notice of Claim under Virginia's Medical Malpractice Act is not a requirement to bring a federal cause of action under COBRA was affirmed; the trial court's ruling sustaining the demurrer on the ground that a COBRA claim had not been properly pleaded was reversed, and the case was remanded for trial on the merits.

The threshold question in this case is jurisdiction of this Court to review the Virginia Supreme Court decision.

REASONS WHY THE PETITION SHOULD BE DENIED

I. THE JUDGMENT OF THE VIRGINIA SUPREME COURT OVERRULING A DEMURRER IS NOT A REVIEWABLE FINAL ORDER UNDER 28 U.S.C. §1257(A).

A. In civil litigation, the judgment of the highest state court relating to a demurrer or motion to dismiss a complaint is final only if the case is thereby disposed of conclusively.

Congress has limited the Supreme Court's power to review judgments from state courts. Only "final" judgments are subject to review under 28 U.S.C. §1257(a).

In Bostwick v. Brinkerhoff, 106 U.S. 3 (1882), a negligence suit by a stockholder against the directors of a national bank, the Court stated that to be "final", the judgment:

> must terminate the litigation between the parties on the merits of the case, so that if there should be an affirmance here, the court below would have nothing to do but to execute the judgment or decree it had already rendered....If the judgment is not one which disposes of

the whole case on its merits, it is not final. Consequently, it has been uniformly held that a judgment of reversal with leave for further proceedings in the court below cannot be brought here on writ of error. 106 U.S. at 3-4.

In Bostwick, the New York trial court had sustained a demurrer, the New York Court of Appeals had reversed with leave to the defendant to answer the complaint and with direction that the case be returned to the trial court and "proceeded with according to law". The defendant applied to this Court for a writ of error which was denied on the ground that the judgment below was not final because it still remained to be decided whether the defendants were negligent. Similarly, the Virginia Supreme Court has remanded this case to the trial court for further proceedings to determine if the Hospital has violated COBRA. Bostwick was followed in Meagher v. Minnesota Thresher Mfg. Co., 145 U.S. 608 (1892), where the state appellate court had affirmed a trial

court's order overruling a demurrer. Meagher was followed in Werner v. Charleston, 151 U.S. 360 (1894); See also Missouri v. Kansas Interurban Railway Company v. City of Olathe, Kansas, 222 U.S. 185 (1911); Urie v. Thompson, 337 U.S. 163 (1949); Clark v. Kansas City, 172 U.S. 334 (1899); Louisiana Navigation Co. v. Oyster Comm'n of Louisiana, 226 U.S. 99, 57 (1912); *per curiam* opinions in Nichols v. The City of Clevland, 220 U.S. 602 (1910); Meyers, Trustee, Etc. v. Samuels, et. al., 223 U.S. 715 (1911); Clinger, Administratrix, Etc. v. Chesapeake & Ohio Railway Co. of Ky., et. al., 226 U.S. 602 (1912); McCabe, Administratrix v. The Maysville & Big Sandy Railroad Company et. al., 226 U.S. 601 (1912).

No exceptions to these general rules apply in this case. There is no threat of serious diversion of national policies such as a denial of constitutional rights. There

is no need for immediate review of the issue raised. No irreparable harm will suffer if the Petitioner must face trial. The Petitioner has other defenses that it can interpose at trial. Discovery, which has not yet been conducted, could lead to an amendment of pleadings as evidence is developed. The case may be settled at or before trial. The Respondents may lose on the merits and the case may not be appealed to this Court. The Petitioner may lose at trial and may not appeal further.

B. Jurisdiction should not be exercised in piecemeal proceedings. This Court does not render advisory opinions. Smith is not in conflict with any decision of this Court, any other state court or any court of appeals.

This Court has repeatedly stated that jurisdiction should not be exercised in piecemeal proceedings. Louisiana Navigation Co. v Oyster Comm'n of Louisiana, 226 U.S. 99 (1912), *supra*, where this Court stated "the form of the judgment is controlling" and this

Court cannot "disregard the form of the judgment". Since the appellate court judgment order on its face had remanded the cause to the lower court, it was not final and the appeal was dismissed. The form of judgment of the Virginia Supreme Court in this case was: "For the reasons discussed above, the judgment of the trial court will be affirmed in part and reversed in part, and the case remanded for further proceedings." (Petition, A-34-35).

This Court has repeatedly stated that it does not render advisory opinions. Were the Court's reviewing power not limited to "final" judgments, litigants would be free to come to the Court and seek decisions on federal questions which, after later proceedings, might subsequently prove to be unnecessary and irrelevant to a complete disposition of the litigation. Such would be contrary to the interests of judicial economy. The

overruling of a demurrer, like the issuance of a temporary injunction, is not ordinarily a "final" judgment unless some important federal question is involved which is ripe for adjudication. Pope v. Atlantic Coast Line R. Co., 345 U.S. 379, 382 (1953). In Pope, this Court stated "We have not interpreted §1257 so as to preclude review of federal questions which are in fact ripe for adjudication when tested against the policy of §1257". However, in Pope, the state supreme court decision was in conflict with decisions of this Court and was ripe for decision. 345 U.S. at 381. Nothing remained to be done but the mechanical entry of judgment by the trial court; therefore, the court found it had jurisdiction. In this case, to the contrary, there is more to be done than the mechanical entry of a judgment. Discovery and trial remains. There is no need to render an advisory opinion on a statute which is plain on its face.

The decision of the Virginia Supreme Court in Smith is well reasoned and is not in conflict with any other state court of last resort or federal appeals court. The decision is consistent with rulings of a court of appeals. See, Thornton v. Southwest Detroit Hosp., 895 F.2d 1131 (6th Cir. 1990); Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990). The Virginia Supreme Court cited the language of the Sixth Circuit in Thornton which rejected the Hospital's argument that the Act's requirement of care for a patient did not extend beyond the emergency room to the intensive care and in-patient areas. The court reasoned that COBRA was intended to "insure that patients with medical emergencies would receive emergency care...[which] does not...stop when a patient is wheeled from the emergency room into the main hospital." Id. at 1135. 243 Va. at 452 (Pet. A-20-21).

The Virginia Supreme Court also followed Cleland v. Bronson Health Care Group which held the statute to be clear and unequivocal on its face. Moreover, the Virginia Supreme Court, which is one of the most conservative courts in the country, has not decided a federal question in a way which conflicts with any decisions of the United States Supreme Court. See Sup. Ct. R. 10.

C. The Petitioner's reliance on the fourth exception of Cox Broadcasting Corp. v. Cohn, 420 U.S. 469 is misplaced. No federal policy will be seriously eroded if the Court refuses to immediately review this state court decision.

The Petitioner fails to cite or distinguish the above cited cases but relies on the fourth exception in Cox Broadcasting Corp. v. Cohn (Pet. at 13), applied in Goodyear Atomic Corp. v. Miller (Pet. at 14) and Southland Corp. v. Keating (Pet. at 15).

Cox involved the Constitutional exercise of

freedom of the press in a rape case. No demurrer was involved. A Georgia Statute permitted suit against the press for publishing the name of a rape victim. The Statute was upheld by the Georgia Supreme Court. While the Georgia Supreme Court had remanded the rape case for trial on the merits, this Court noted that delay of review "until after trial...will leave the press in Georgia operating in the shadow of the civil and criminal sanctions of a rule of law and a statute the constitutionality of which is in serious doubt." 420 U.S. at 485-486. For that reason, this Court granted review. However, no such immediacy exists here. No Constitutional question is involved here.

In Goodyear Atomic Corp. v. Miller (Pet. at 14), relied on by Petitioner, neither party contested this Court's appellate jurisdiction. 486 U.S. at 178. No demurrer was involved. That case involved "the only

nuclear facility producing nuclear fuel for the Navy's nuclear fleet." The Ohio decision had "important implications for the regulation of federally owned nuclear production facilities in other States." 486 U.S. at 180. The Ohio ruling, which increased a workers' compensation award for an injury on federal property where an Ohio safety regulation was violated, involved the issue of violation of the Supremacy Clause of the Federal Constitution. Under those circumstances and out of concern that the Ohio decision might seriously erode important federal policy "in the area of nuclear production", this Court granted review of the state-court decision. 486 U.S. at 179. No such issues are involved here.

In Southland Corp. v. Keating (Pet. at 15), no demurrer was involved and the question, like in Goodyear, supra, centered around the Supremacy Clause.

A California Statute invalidated certain arbitration agreements covered by the Federal Arbitration Act which declared a national policy favoring arbitration. Under those circumstances, this Court granted immediate review because a refusal to review might seriously erode federal policy. The Supremacy Clause is not involved in this case. The Federal anti-dumping Statute is clearly written and no irreparable harm will come to hospitals who must comply with the law.

This Court does not have jurisdiction to review under 28 U.S.C. §1257 and should decline the invitation to review this case because (1) this civil action has been remanded for further proceedings on the merits at the trial level; (2) the litigation between the parties has not been terminated by the Virginia Supreme Court's ruling; (3) there may be an amendment to the pleadings; (4) the Petitioner will not be prevented from raising defenses at

trial; (5) there is no threat of serious diversion of national policies such as a denial of constitutional rights; (6) the Virginia Supreme Court's ruling is not in conflict with any decision of this Court or with any decision of any of the Federal Circuits or with other state supreme court decisions; (7) this Court does not render advisory opinions and exercise its jurisdiction in piecemeal fashion; (8) future appellate review by this Court would not be precluded by a refusal to review; (9) no federal policy such as a violation of the Supremacy Clause will be seriously eroded by refusal to review; and (10) there is no substantially important federal question presented.

ARGUMENT

The thrust of the Petitioner's argument is that the mother did not allege she first presented to the emergency room of the hospital (Pet. 21, 26, 30) and

that HCFA's construction does not accord with the Virginia Supreme Court's interpretation of 42 U.S.C. §1395dd (Pet. 31-37, 40, 47-48). The Petitioner also suggests it transferred the mother out of "medical necessity", that it is excused if it transfers a patient to a hospital with superior facilities (Pet. 21, 27) and that the Act does not apply to paying patients (Pet. 21). Furthermore, the Petitioner asserts the Virginia Supreme Court "failed to apply appropriate principles of statutory construction" (Pet. 31). Lastly, the Petitioner maintains that Virginia's Notice of Claim procedure for Medical Malpractice cases is not preempted by the Act.

II. THE ACT DOES NOT REQUIRE AS A PREREQUISITE FOR COVERAGE THAT A PATIENT FIRST PRESENT TO THE HOSPITAL'S EMERGENCY ROOM OR THAT THE DISCHARGE BE FROM THE EMERGENCY ROOM. IT COVERS ANY PATIENT WHO COMES TO A HOSPITAL OR IS A PATIENT AT A HOSPITAL.

The Virginia Supreme Court's literal interpretation of the Act is reasonable. Referring to §1395dd(c) in its opinion (Pet. A-15-18, 243 Va. at 451), the Court stated "If a patient *at a hospital* has an emergency medical condition which has not been stabilized...or is in active labor, the hospital may not transfer the patient" unless certain requirements are met. As stated by the Virginia Supreme Court, "The language used in each subsection [(a), (b) and (c)] describes distinct patient circumstances requiring different treatment protocols. If an individual "comes to the emergency department" [a] the hospital must provide an appropriate medical screening examination...If an individual "comes to a hospital" [b] and the hospital determines that an emergency medical condition or active labor exists, the hospital must stabilize the condition or transfer the person...If a "patient at a

hospital" [c] has an emergency condition or is in active labor, the hospital may transfer that patient only under certain conditions. Id. §1395dd(c)." (Pet. A-17). The Virginia Supreme Court noted "we find nothing in the language of the Act which limits application of these subsections solely to a patient who initially arrives at the emergency room and who has not been stabilized, as the Hospital argues here." 243 Va. at 452. (Pet. A-18). COBRA applies to any individual who has an emergency medical condition or goes into active labor "while at a hospital".

Before the Virginia Supreme Court's decision in Smith was published, a federal district judge in Norfolk, Virginia, decided this precise issue in an identical fashion. In McIntyre v. Schick, M.D. et. al., 1992 WL 134713, Opinion June 16, 1992, the sole basis for the defendant hospital's motion to dismiss was that plaintiffs

"failed to plead, pursuant to §1395dd(a), that Mrs. McIntyre presented to the emergency department of the hospital." That Court stated:

> Although the court agreed that, under subsection (a), one would have to present to a hospital's emergency department in order to state a claim under that subsection, Plaintiffs did not plead their case under subsection (a), and the court reads subsection (a) separately from subsections (b) and (c). Nothing in the language of §1395dd indicates that every other provision in the statute must be read in conjunction with subsection (a), and neither subsections (b) nor (c) refers back to the requirements of subsection (a). Moreover, subsection (b) never mentions the words "emergency department" or "emergency room". See 42 U.S.C. §1395dd(b). The only reference to the "emergency department" in subsection (c) is made with respect to medical personnel permitted to sign a certification of patient transfer. See 42 U.S.C. §1395dd(c)(1)(A)(ii)... .....Nowhere do subsections (b) and (c) state that an individual in an emergency medical condition or in active labor must enter through the emergency room. Nor does the statute state that such a person present in another department of the hospital first must be sent to the emergency room for a determination of that individual's status.

Furthermore, although the terms "emergency department" and "emergency room" were often used in the legislative history of § 1395dd, e.g., H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 27 (1986), reprinted

in 1986 U.S. C.C.A.N. 42, 605; H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. III at 6 (1986), reprinted in, 1986 U.S.C.C.A.N. 42, 726-27, other statements in the statute's legislative history demonstrate that legislators were concerned with protecting those in need of emergency medical care, not just those who presented to the emergency room of a hospital. See, e.g., H.R. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 27 (1986), reprinted in 1986 U.S.C.C.A.N. 42, 605 ("The Committee is most concerned that medically unstable patients are not being treated appropriately."); 131 Cong. Rec. S13903 (daily ed. October 23, 1985) (statement of Sen. Durenberger ("We cannot stand idly by and watch those Americans who lack the resources be shunted away from immediate and appropriate emergency care whenever and wherever it is needed .... [T]he Medicare program will not do business with any institution which willfully and knowingly, or through negligence, turns its back on an emergency medical situation").

The Sixth Circuit shares this court's view. In commenting on § 1395dd's legislative history, the court disagreed that the repeated use of the term "emergency room" indicated that Congress intended that the requirement to care for a patient in an emergency medical condition extended only to those entering through the emergency room. "A fairer reading is that Congress sought to insure that patients with medical emergencies would receive emergency care." Thornton v. Southwest Detroit Hospital, 895 F.2d 1131, 1135 (6th Cir. 1990).

Although not directly on point, both the Loss v.

Song, No. 89C 6952, 1990 WL 15961 (N.D. Ill. Oct. 16 1990), and Thornton cases support this broader interpretation of the statute. In Loss, a baby whose mother had been admitted to the hospital was born with an emergency medical condition. The plaintiff's doctor released mother and child without first stabilizing the child. The child died soon thereafter from complications arising from his condition. In denying the defendant's motion to dismiss, the court held that the fact that the baby did not come in through the emergency room was not fatal to the COBRA complaint, and that a child with an emergency medical condition, born to a mother admitted to the hospital, must be treated under the provisions of COBRA. Id. at *4.

In Thornton, quoted supra, a patient came to the emergency room after suffering a stroke and was admitted to the hospital. She alleged that her condition was not stabilized while she was admitted, but that she was released anyway. The court held that the provisions of the COBRA anti-dumping statute applied to her, as well, stating:

> Hospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient. Emergency care must be given until the patient's emergency medical condition is stabilized .... Although emergency care often occurs, and almost invariably begins, in an emergency room, emergency care does not always stop when a patient is wheeled from the emergency room into the main hospital.

Id. at 1135. Both Loss and Thornton demonstrate that the rationale behind the COBRA patient anti-dumping statute is not based upon the door of the hospital through which a patient enters, but rather upon the notion of proper medical care for those persons suffering medical emergencies, whenever such emergencies occur at a participating hospital. Indeed, it is a ridiculous distinction, one which places form over substance, to state that the care a patient receives depends on the door through which the patient walks.[5]

III. MS. SMITH'S PRESENTATION TO THE EMERGENCY ROOM IS MOOT BECAUSE THE HOSPITAL HAD A POLICY THAT PATIENTS IN LABOR GO DIRECTLY TO LABOR AND DELIVERY.

Ms. Smith was received in the Labor Room by wheelchair at 0600 on July 18, 1988 with spontaneous rupture of membranes. (Exhibit F with trial court brief). The Rules and Regulations of the Division of OB/GYN of the hospital (App. A, Exhibit G, below at 41) required:

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[5]In fact, at the hearing, Defendant VBGH admitted that, had she entered through the emergency room, Theresa McIntyre probably would have been taken to Labor and Delivery anyway.

All pregnant patients of 20 or more weeks gestation who present to Richmond Memorial Hospital with the complaint of labor will be evaluated initially in Labor and Delivery.

The above was called to the attention of the trial court and the Virginia Supreme Court (App. below, 41, 53, App. D).

If Petitioner's contention that a woman must be first admitted through the Emergency Room is correct, then no woman pregnant greater than 20 weeks could ever maintain a COBRA action against Richmond Memorial Hospital because all such patients, like Ms. Smith, are admitted directly to Labor and Delivery. Such a conclusion would lead to other unreasonable results when patients need specialized services. For example, a patient who needs an M.R.I. scan may bypass the Emergency Room and go directly to the Radiology Department. As Petitioner's Appendix G points out, "Some services cannot be made available through an

emergency room or are available only during certain hours because staff are not available at all times." (Pet. G-12).

IV. ADMINISTRATIVE LETTERS AND HCFA INTERPRETATIVE GUIDELINES WHICH DO NOT HAVE THE FORCE AND EFFECT OF LAW ARE NOT MADE PURSUANT TO DELEGATED AUTHORITY AND ARE NOT BINDING ON COURTS. SUCH GUIDELINES WERE NOT MADE A PART OF THE TRIAL RECORD OR THE APPENDIX TO THE VIRGINIA SUPREME COURT

The American Hospital Association has attempted to persuade HCFA to enact regulations favorable to its position. (e.g. Pet. G-27-28)[6]. However, the HCFA has not yet enacted any final regulations.[7]

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[6] e.g., "We believe that our suggestions represent a sensible interpretation of the new requirements..." (G-27) and "We also urge HCFA to reflect these interpretations in its own regulations...." (G-27).

[7] On September 17, 1990, HCFA expected to publish a final regulation "within the next few months." (Pet. H-3). It was reported on May 25, 1992 that HCFA has still not enacted final regulations. See *Hospitals Strictly*

Nonlegislative rules of an Agency (interpretative rules and general statements of policy not made pursuant to delegated authority) are not binding on the courts. Rules which do not have the force and effect of law are subject to challenge in any court proceeding in which their application may be in question. See *Koch*, 1 Administrative Law and Practice §3.4.

Petitioner has attached various letters and guidelines as Appendices to its Petition which were neither made a part of the trial record nor the Appendix to the Virginia Supreme Court. Nor were they argued during oral argument to the Virginia Supreme Court on

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Liable for Patient Injuries, 12 Lawyers Alert 11, May 25, 1992 which comments on this case. Under the law, regulations were required to be completed by Spring, 1987. It has been noted that the Secretary of HHS did not promulgate regulations for the first 26 years of the Hill-Burton program. See Karen I. Treiger, Note, Preventing Patient Dumping: Sharpening the Cobra's Fangs, 61 N.Y.U. L. Rev. 1186, 1217 (footnote 196) (1986), cited by the Virginia Supreme Court (Pet. A-10).

February 24, 1992. These documents were first attached to a Petition to Rehear filed by the Petitioner on May 18, 1992, one month after the Court announced its Opinion and three months after oral argument. Petitioner has now attached these documents to its Petition as if they had been made properly a part of the record below.

HCFA has interpreted COBRA similar to the Virginia Supreme Court's decision in Smith. In an unreported case[8] a physician advised a woman 7 1/2 months pregnant to report directly to the Obstetric Service and to bypass the Emergency Room of a hospital in. It was the middle of the night and the physician called a state hospital which provided charity care. The charity hospital advised the physician that it was full and did not have the capacity at that time to treat the mother

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[8] See Pizza, Patient Transfers-COBRA as Amended, 1992 A.B.A. Sec. Pub. 6 The Health Law Letter 2, p. 4.

and child. Nevertheless, the physician put the mother in an ambulance and transported her to that hospital. The charity hospital reported the physician and his hospital to HCFA asserting that the transfer was not in accordance with subsection (C) of 42 U.S.C. §1395dd. Specifically, they had not agreed to accept the transfer. Although no penalty was levied, HCFA did find that the Act had been violated. It required the hospital to engage in an educational process among its medical staff concerning the requirements of COBRA. HCFA ignored the issue of Emergency Department admission and ruled that admission directly to the Obstetric Department of a woman in labor was the same as an admission to the Emergency Department. Specifically, HCFA stated[9]:

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[9] Letter dated July 5, 1989 from Kenneth C. Schneider, M.D., Associate Regional Administrator for Health Standards and Quality (H.C.F.A.) to Allen Tuten, Administrator, Lincoln General Hospital, App. C, p. 2.

> Your hospital claims that, since the patient in question went directly to the obstetrics department "as an outpatient clinic patient" rather than to the emergency room for her initial evaluation, she did not present to the emergency department, and thus deficiencies should not have been referenced to that department. It is our position that the Emergency Services Condition of Participation (and the medical screening requirements of Section 1867) refer to any organized arrangement for the provision of unscheduled, urgent services, and are not intended to dictate a particular departmental structure. , Lincoln General properly instituted an emergency services record on this patient. (App. C, p. 2).

On page 48 of the Petition, Petitioner states "The construction of a statute by the administrative agency that is charged with the responsibility of enforcing it is entitled to great deference." However, in practice, HCFA's enforcement policy is contrary to the Petitioner's position. Furthermore, the 1992 guidelines are not rules and may be modified at any time (See Pet. E-2 wherein it is stated "Our purpose is to outline the anti-dumping provisions in the statute and not to establish rules subject to the notice and comment

provisions of the Administrative Procedures Act. These instructions may be modified, as necessary, in accordance with the forthcoming final regulations.") (emphasis added).

The Petitioner's reliance on Chevron U.S.A. Inc. v. Natural Resources Defense Council, 467 U.S. 837 (Pet. 48) for the proposition of deference is misplaced. First, that case involved EPA "Regulations" which are mandatory, not merely instructions, guidelines and letters. Less weight is accorded guidelines than administrative regulations which have the force and effect of law. General Electric Co. v. Gilbert, 429 U.S. 125, 141 (1976). Secondly, this Court stated in Chevron "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress". 467 U.S. at 842-843. Thirdly, the Statute

involved in Chevron was silent on the subject at hand and involved interpretation. In this case, the words of the Statute[10] clearly speak to the subject and do not need interpretation. Fourthly, the HCFA guidelines (Pet. F-1) in this case were promulgated on January 29, 1992, six years after the enactment of COBRA[11]. Agency guidelines which are not contemporaneous with the enactment of an Act and which have not been consistently applied over time are not given the same weight as those which are. General Electric Co. v. Gilbert, *supra*, 439 U.S. at 142.

Petitioner relies on a self-serving memorandum from the American Hospital Association dated October,

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[10] for example, "comes to a hospital", "patient at a hospital".

[11] Consolidated Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-272, §1921, 100 Stat. 82, 164-67 (codified as amended at 42 U.S.C. §1395dd (Supp. IV 1986). The law was enacted April 7, 1986.

1990 to support a view that the transfer requirements of the Act do not apply to hospital inpatients (Pet. 33-34, F-4-6). An AHA Memorandum is not law. On page 32 of the Petition, Petitioner recites a portion of this AHA Memorandum but omits other relevant AHA statements at F-5-6:

> This does not preclude the possibility that subsequent court judgments may apply the transfer protocols in cases involving inpatients and some hospitals may wish to adopt this broader interpretation pending further judicial action.

The first page of the 1990 AHA Guide (F-2) recites "hospitals must base their compliance action on the statute". (Pet. F-2). The second page states "Each hospital should consult with legal counsel when assessing its compliance with the new requirements." (Pet. F-13). This is a kind way to say "read the statute and cases".

V. THE ACT (42 U.S.C. §1395DD) IS PLAIN ON ITS FACE AND VIRGINIA'S INTERPRETATION OF

THE WORDS OF THE STATUTE DOES NOT SUBVERT THE PURPOSE OF THE LEGISLATION OR LEAD TO AN ABSURD RESULT.

A. While the Act is broader than any or all members of Congress were cognizant of, it is not the place of courts to rewrite a statute which is plain on its face to conform with its notion of efficacy or rationality.

Quoting the Sixth Circuit's language in Cleland v. Bronson Health Care Group, Inc., 917 F.2d 266, 270 (6th Cir. 1990), and agreeing with this rationale, the Virginia Supreme Court stated (Pet. A-26-27):

> Although the legislative history of COBRA indicates Congressional concern with denial of treatment and inappropriate transfers of indigent persons who come to the emergency rooms of hospitals, the plain language Congress chose does not limit the Act to those circumstances. Many courts called on to interpret the language of the Act have reached similar conclusions regarding the breadth of coverage the statutory language provides, in contrast to the more focused scope reflected in the legislative history of the Act. See e.g., Brooker v. Desert Hosp. Corp., 947 F.2d 412, 414-15 (9th Cir. 1991); Gatewood, 933 F2d at 1040; Lee by Wetzel v. Alleghany Regional Hosp. Corp., 778 F. Supp. 900, 902 (W.D. Va. 1991); Delaney v. Cade, 756 F. Supp. 1476, 1485-86 (D. Kan. 1991). As stated by the court in Cleland v. Bronson Health Care Group, Inc.:

> The words of the statute....are quite plain, and interpreting them as such does not lead to an absurd result. It leads to a result considerably broader than one might think Congress should have intended, or perhaps than any or all individual members of Congress were cognizant of. However, it is not our place to rewrite statutes to conform with our notions of efficacy or rationality. That is the job of Congress....Here, the result we reach in no way vitiates or is contrary to Congress's indicated concern in passing the legislation. It may go further than what Congress contemplated, but that is not a reason to distort or excise the words that Congress wrote. 917 F.2d at 270.

COBRA has been interpreted broadly by federal courts and not narrowly in disregard of the plain meaning of the Statute. Thompson v. St. Anne's Hospital, 716 F. Supp. 8, 10 (N.D. Ill. 1989); DeBerry v. Sherman Hospital Association, 741 F. Supp. 1302, 1307 (N.D. Ill. 1990); Burroughs v. Turner Memorial Hospital, 762 F. Supp. 762, 842 (W.D. Ark. 1991). If a statute is clear and unequivocal on its face, it is not necessary to resort to legislative history as Petitioner attempts to do (Pet. 40-46). Brooker v. Desert Hospital Corp., 947 F.2d 412,

414 (9th Cir. 1991), cited by the Virginia Supreme Court (Pet. A-25-26).

B. Whether or not a patient has insurance or is able to pay for his hospitalization is irrelevant to COBRA coverage.

COBRA draws no distinction between persons with and without insurance. Gatewood v. Washington Healthcare Corp., 933 F.2d 1037, 1040 (D.C. Cir. 1991). The Statute clearly provides that it applies to anyone who comes to a hospital "whether or not eligible for benefits (Medicaid) under this title." 42 U.S.C. §1395dd(b)(1). Petitioner's suggestion that Ms. Smith was "covered by health insurance" (Pet. 10) and that "she was transferred to MCV because she was uninsured or unable to pay" is irrelevant (Pet. 21).

C. Further statements made in the Petition are irrelevant to this inquiry.

It is irrelevant that Ms. Smith was "one centimeter dilated" on transfer (Pet. 8-9). The Act, 42

U.S.C. §1395dd(e)(1)(C), defines active labor to include a transfer which "may pose a threat [to] the health and safety of the patient or the unborn child." In Burditt v. U.S. Department of Health and Human Services, 934 F.2d 1362, 1369 (5th Cir. 1991), the court stated "This statutory definition renders irrelevant any medical definition of active labor." and that the provisions of the Act protect "women in labor who have any complication with their pregnancy regardless of delivery imminency".

It is irrelevant that the infant was born "more than seven hours after arrival" at MCV (Pet. 9). Whether or not transfer "may pose a threat...depends on whether the woman in labor has any medical condition that could interfere with the normal, natural delivery of her healthy child". The Act protects against a "possible" threat. 934 F.2d at 1370. Premature rupture of membranes, the likely need for a repeat Caesarean operation and

chorioamnionitis, conditions affecting the mother in this case, are conditions which can interfere with the normal, natural delivery of a healthy child. As noted by the Executive Vice-President of the AHA (Pet. G-14), "In such a case, 'stabilization' would require delivery of the baby." There is a clear intention on the part of Congress to protect the unborn child.

It is irrelevant if the hospital may believe the transfer was in the "best interest of the patient" (Pet. 5). "Transfer" refers to the illegal "movement" of a patient. 42 U.S.C. §1395dd(e)(5). What is strictly prohibited by the Act is the failure to provide "treatment" of an emergency medical condition or to provide treatment for the labor and the inappropriate "transfer" of a patient with such conditions without the "certification" required. 42 U.S.C. §1395dd(c)(1)(A)(ii). The Statute does not require that an improper, or nonmedical, motive for

transfer be proved as an element for transfer. 934 F.2d at 1373.

It is irrelevant that "Dr. Jones gave the order for Connie Smith's transfer" (Pet. 8). Hospitals can "act and know things only vicariously through individuals". Any violation of the Act by a "physician is also a violation by the hospital". 934 F.2d at 1374.

The Statute does not excuse a transfer to a better-equipped hospital. If such were the case, there could never be a case of patient-dumping when the transfer is from a Level I to a Level II or from a Level II to a Level III hospital. The higher level hospital is always better equipped. In Owens v. Nacogdoches County Hosp. Dist., 741 F. Supp. at 1370 (cited by Petitioner at Pet. 24), the court found the argument that the transfer was to a Level III hospital with a neonatal unit to be "unavailing". In Lee by Wetzel v. Alleghany Regional

Hosp. Corp., 778 F.Supp. 900, 902 (W.D. Va. 1991), the transfer was to a "better equipped hospital", but was held to be covered under the Act. The issue is not whether the transferee hospital is better equipped, but whether or not the transfer took place at a potentially dangerous, and therefore, impermissible point in time and whether or not the treat or transfer requirements were met.

There is no proof of any relationship between "the skyrocketing cost of malpractice insurance" as suggested (Pet. 20) and patient-dumping claims, all of which arose after 1986. Insurance rates were a problem before then and must be related to something else. There is no basis to suggest this is a "meritless suit". (Pet. 20). The Statute imposes a strict liability standard. Stevison v. Enid Health Sys., Inc., 920 F.2d 710, 713 (10th Cir. 1990).

The Court should deny the Hospital's Petition

because (1) the plain language of COBRA does not require that a patient first present to an emergency room before the patient is entitled to coverage; (2) that point is moot in this case; (3) the plain language of the Act applies to any patient who "comes to a hospital" or is "at a hospital"; (4) Virginia's interpretation of the Act does not subvert the purpose of COBRA or lead to an absurd result; and (5) the Court should give no deference to HCFA letters and guidelines not properly made a part of the record below and which do not have the force and effect of law.

VI. COBRA WHICH CREATES A FEDERAL CAUSE OF ACTION BASED ON STRICT LIABILITY AS DISTINGUISHED FROM AN ACTION FOR MEDICAL MALPRACTICE PREEMPTS VIRGINIA'S REQUIREMENT OF PRIOR WRITTEN NOTICE APPLICABLE TO VIRGINIA MEDICAL MALPRACTICE ACTIONS.

COBRA does not preempt state law except to the extent any state or local law directly conflicts with its

provisions. §1395dd (f). Since COBRA has no notice requirement, Virginia's mandatory requirement of notice is a procedural hurdle in direct conflict with COBRA. Both the trial judge and the Virginia Supreme Court unanimously held that the Notice provision is inapplicable to a COBRA federal cause of action. 243 Va. at 455-457 (Pet. A-30-35, B-12-15). As noted by the Virginia Supreme Court, "The Virginia notice provisions not only require a plaintiff to provide written notice of the claim to the health care provider, they also absolutely prohibit the filing of a medical malpractice claim against the health care provider until 90 days after such notification and, if the health care provider chooses to have the issue reviewed by a malpractice review panel, the suit cannot be filed until the panel completes its review. Code §8.01-581.2(A). The state statute of limitations is tolled during this period. It is this aspect of

the notice of claim provision which is in direct conflict with the provisions of COBRA." 243 Va. at 456.

42 U.S.C. §1395dd(d)(3)(C) provides for a federal limitation period of two years to bring a civil action under COBRA.

Relying on Burroughs v. Turner Memorial Hosp., Inc., 762 F. wpp. 840, 843 (W.D. Ark. 1991), the Virginia Supreme Court held that "the tolling provision of the state statute cannot act to toll the running of the statute of limitations established in federal legislation which created a federal right of action." 243 Va. at 456. Burroughs, citing Garrison v. International Paper Co., 714 F.2d 757, 759 n. 2 (8th Cir. 1983) and Holmberg v. Armbrecht, 327 U.S. 392, 395 (1946), held that "the claims on which the statute of limitations is extended are only those to which a statute of limitations determined by *state law* applies." (emphasis added). 762 F. Supp. at

843.

Petitioner cited a footnote in a secondary source as authority for its assertion that "Where a federally created cause of action is filed in state court, state procedural rules regarding commencement and tolling apply, even where the statute of limitations is federally prescribed." (Pet. 53). Petitioner did not discuss the case cited in the footnote. The case referred to in the footnote[12] is a state case which involved the federal Portal-to-Portal Act which specifically incorporated the "period prescribed by the applicable State statute of limitations". Sauerzopp v. North American Cement Corporation, 92 N.E.2d 617 (N.Y. 1950). COBRA does not borrow or incorporate state limitation periods. Exceptions to the general rule that the federal limitation

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[12] 2 J. Moore, J. Lucas, H. Fink, & C. Thompson, Moore's Federal Practice ¶ 3.09[2]n. 15 (2d ed. 1991) (Pet. 53).

period applies and is not tolled by state statutes do not exist here.[13] In Felder v. Casey, 487 U.S. 131, 138 (1988), this Court held that a state's notice of claim statute was inapplicable to a claim brought under 42 U.S.C. §1983 because it would conflict with 42 U.S.C. §1983's purposes and objectives and would frequently and predictably produce different outcomes in §1983 litigation based solely on whether the action is brought in state or federal court. Adherence to such a notice requirement would also burden the exercise of the federal right and would be inconsistent with the compensatory aim of federal civil rights laws. Similarly, Virginia's notice requirements applicable to state medical malpractice actions would burden the deterrent and compensatory aims of COBRA by delaying the filing of

[13] e.g., improper venue, misrepresentation, or war has prevented a plaintiff from bringing his suit. Burnett v. New York Cent. R. Co., 380 U.S. 424, 428-29 (1965).

COBRA actions in state courts and by delaying an award of compensation to the patient who is illegally dumped. Virginia's notice requirement is a procedural hurdle to a plaintiff not contemplated by Congress, and if permitted, would produce different outcomes based solely on whether the action was brought in state or federal court.

Virginia's Medical Malpractice Act is substantively irrelevant to a COBRA claim. The giving of notice under Virginia's Medical Malpractice Act merely triggers the appointment of a medical malpractice review panel, if requested by any party. The plaintiff who wishes to proceed may not file a civil action until 90 days after giving Notice (if no panel is requested) or 90 days after the decision of the Panel if a panel is requested. (Pet. A-32). Panel proceedings often delay medical malpractice cases from a few months to a year in Virginia. When there is a trial, the opinion of the

Panel is admissible into evidence but is not binding on the jury.

The Virginia medical malpractice standard of care is irrelevant to a federal COBRA action in which the only issue is whether or not there has been a violation of 42 U.S.C. §1395dd. Nowhere in COBRA does it state that a state malpractice review panel is permitted to pass on the issue of a COBRA violation before suit can be brought. Nowhere in COBRA does it state that the opinion of a medical malpractice review panel is admissible into evidence at trial.

Additionally, the Panel must apply Virginia's "statewide" standard of care applicable to medical malpractice cases. Under Virginia law, "standard of care" means that degree of care practiced by a health care provider "in this Commonwealth". Va. Code Ann. §8.01-581.20A. Before the enactment of COBRA, the standard

of care in Virginia and elsewhere did not require a hospital to treat a patient or prohibit the hospital's transfer of a patient. Thornton v. Southwest Detroit Hosp., *supra*, 895 F.2d at 1133. The Virginia "standard of care" is irrelevant to a federal COBRA claim.

Petitioner's suggestion (Pet. 50) that Virginia's Notice provision applies to this federal action because Virginia's Medical Malpractice Act applies to "any tort" is also not persuasive. Va. Code Ann. §8.01-581.1. The remainder of the definition in the Virginia statute qualifies "any tort" as one "based on health care or professional services rendered, or which should have been rendered by a health care provider to a patient." 42 U.S.C. §1395dd(e)(5) restricts transfers of certain patients. "Transfer" refers to the "movement" of a patient. The "movement" of a patient in violation of COBRA is not "malpractice" as defined in Virginia's

Medical Malpractice Act and is not a violation of the Virginia standard of care.

The federal district court in Northern Virginia has held that Virginia's notice requirement is a "procedural obstacle" that would "seem to be directly at odds with the purpose, the structure and the language of [COBRA]". Toliver v. Culpepper Memorial Hosp., C.A. No. 90-0501-A, slip op. (E.D. Va. Au. 30, 1991), relied on by the trial judge in Smith (Pet. B-13-14). Another federal judge in the Eastern district of Virginia recently held that Virginia's total medical malpractice cap of one-million dollars, like the notice requirement, does not apply to federal COBRA actions. That judge noted that the cap would have the same potential to frustrate the goals of deterring "patient dumping" and compensating victims as would the notice requirement. Susan M. Power v. The Arlington Hospital, 1992 WL 210588

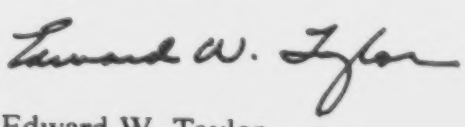
(E.D. Va. August 28, 1992).

The Court should deny the Hospital's Petition because Virginia's Notice requirements applicable to Virginia Medical Malpractice proceedings do not apply to this federal cause of action which establishes a two-year federal limitation period.

CONCLUSION

For the reasons stated above, the Hospital's petition for certiorari should be denied.

Respectfully submitted,



Edward W. Taylor
Counsel of Record
Taylor & Schockemoehl, P.C.
601 North Courthouse Road
Richmond, Virginia 23236
Counsel for Respondents

October 2, 1992

APPENDIX A

RICHMOND MEMORIAL HOSPITAL

RICHMOND, VIRGINIA

RULES AND REGULATIONS

DIVISION OF OB/GYN

Approved: /s/ James E. Jones, Jr.

James E. Jones, Jr., M.D.

Chairman, Division of OB/GYN

/s/ Laurie E. Rennie

Laurie E. Rennie, M.D.

President, Professional Staff

/s/ James Watkinson

James Watkinson

Chairman, Board of Trustees

Reviewed and Approved:

January 1988

4. Elective Inductions--these may be done from Monday through Friday, exclusive of holidays. They should not be started before 7:30 a.m. or after 4:30 p.m. If the above rules delay the induction beyond the 4:30 p.m. cut off time, the induction may be started whenever the personnel is available.

5. Any admission to the Ob/Gyn service shall be seen by the attending physician within a reasonable period of time.

ARTICLE III

A. LABOR AND DELIVERY

1. Delivery Room #3 will be used as a birthing room. Rules and Regulations will be drawn up according to State of Virginia guidelines and approved by the division.

2. Vaginal examinations shall be done under sterile precautions on all patients in labor or thought to be in labor, or for the purpose of rupturing membranes.

3. Gowns shall be worn by all those attending patients in the labor area, and these shall not be worn out of the labor area. Boots or conductive shoes should also be worn in the Delivery Room.

4. Appropriate apparel should be worn by all people in the Delivery Room.

5. All ancillary personnel entering this area should put on Delivery Room gowns before proceeding across the red line separating this area from the dirty area.

6. Babies leaving Labor and Delivery shall be transported directly to the nursery in

an enclosed Armstrong Unit or in a resuscitator.

7. Under no circumstances should an attempt be made to dely the imminent birth of a child, either by physical restraint or deep anesthesia.

8. When nursing personnel are busy in Labor and Delivery area, the attending physician who has a patient in labor at the time should be notified if it would be impossible for them to suitably watch her.

9. All pregnant patients of 20 or more weeks gestation who present to Richmond Memorial Hospital with the complaint of labor will be evaluated initially in Labor and Delivery. L & D personnel will contact the physician for evaluation

instructions. As part of this evaluation, patients will be evaluated for cervical dilitation and fetal monitoring for an appropriate period of time as determined by the physician. The L & D nurse will contact the physician with the report of the observation period. The physician will determine the disposiiton of the patient and will review and sign the record of such disposition within 24 hours of the patient's arrival.

APPENDIX B

RICHMOND MEMORIAL HOSPITAL

RICHMOND, VIRGINIA

RULES AND REGULATIONS

DIVISION OF OB/GYN

Approved: /s/ James E. Jones, Jr.

James E. Jones, Jr., M.D.

Chairman, Division of OB/GYN

/s/ Laurie E. Rennie

Laurie E. Rennie, M.D.

President, Professional Staff

/s/ James Watkinson

James Watkinson

Chairman, Board of Trustees

Reviewed and Approved:

January 1988

ARTICLE VI

RULES REGARDING SPECIAL DRUGS

A. Induction or augmentation of labor with oxytocin may be initiated only after a responsible physician has evaluated the patient, determined that induction or augmentation is beneficial to the mother or fetus, recorded the indication, and established a prospective plan of management. A physician should examine the patient vaginally immediately prior to the oxytocin infusion. The use of oxytocin on labor and delivery should follow the following protocol:

1. Establish a functional IV line.
2. Mix 10 units of oxytocin in 1 liter of IV fluids (preferably a balanced solution D51/2NS, D5RL, D5NS, etc.)

3. Use a constant infusion device to administer the oxytocin starting at lmU per minute. The rate can be doubled every 15 to 20 minutes until good contractions are elicited.

4. While oxytocin is being administered, the patient should be constantly monitored for adequacy of contractions and frequency of contractions. Fetal heart rate should also be monitored continuously. Personnel who are familiar with the effects of oxytocin and able to identify both maternal and fetal complications should be in attendance while oxytocin is being administered. A qualified physician should be readily accessible to manage any complications that may arise during

infusion.

B. All patients started on Apresoline or Yutopar should be seen within a reasonable period of time.

ARTICLE VII

CONDUCT OF LABOR

A. Patients who are admitted to the Labor Room in active labor or those being prepared for induction of labor shall be assigned to a labor room. Their care and supervision shall be carried out by the Labor Room personnel under the direction of the attending physician. All orders during labor shall be given by a physician. In those cases where an attendant of the patient is admitted to the Labor Room, the attendant shall be properly gowned and under the direct supervision of the nursing staff. The attendant is allowed the privilege of

admission to the Delivery Suite only with the permission of the obstetrician.

B. It is recommended that patients presenting with active labor and gestational ages between 24 and 32 weeks be transferred in utero to the Medical College of Virginia if medically possible.

APPENDIX C

July 5, 1989

Allen Tuten, Administrator
Lincoln General Hospital
Post Office Drawer 1368
Ruston, Louisiana 71273

Dear Mr. Tuten:

In a letter dated June 19, 1989, representatives of Lincoln General Hospital requested an informal administrative review of our institution of termination action based upon the State agency's June 14, 1989 finding of noncompliance with Medicare Conditions of Participation. Your hospital challenges the State survey finds in regard to each of the three Conditions cited: Compliance with Federal, State, and Local Laws because of a violation of Section 1867 of the Social Security Act, the so-called COBRA anti-dumping requirements; Quality Assurance; and, Emergency Services.

You allege that Lincoln General Hospital has taken measures to prevent recurrence of incidents which may violate Medicare patient transfer requirements, and that it has strengthened its quality assurance program. In the belief that your emergency department was always in compliance with the Medicare Condition of Participation, you state that no specific changes were made except to implement improvements in transfer protocols, record-keeping, and in the monitoring of transferred patients.

Your hospital's attorney rejects any assertion that the physician who directed the transfer of the patient in question was the "responsible physician" under Section 1867, since he was not a hospital employee and he had no contractual obligation to assume professional responsibility for the transfer of patients. While the definition of "responsible physician" is important in determining possible eligibility for civil monetary penalties assessed by the Office of Inspector General, it does not bear upon HCFA action to terminate the provider agreement. At issue in our determination is whether the transfer of the patient was "appropriate...in which the receiving facility...has agreed to accept the transfer of the patient and to provide appropriate medical treatment...."

In reaching our conclusion that the transfer was not "appropriate," we did take into consideration the fact that Lincoln General Hospital lacked the capacity to provide optimal continuing care for high-risk newborns, and usually transferred such infants, or women in labor who were expected to deliver infants requiring admission to a Newborn Intensive Care Unit, to other, properly equipped hospitals.

However, we found that, following refusal by LSU Medical Center to accept the patient in question, Lincoln General Hospital did not contact other, equally accessible hospitals, which might have agreed to accept the transfer. This happened because Lincoln General followed an established pattern of utilizing LSU for all indigent and Medicaid patients. Further, since the patient was in "active labor" as defined in Section 1867 (because the transfer may pose a threat to the health and

safety of the unborn child), and the transfer was physician-directed, there should have been certification by a qualified medical person that the benefits expected from the transfer outweighed the increased risks. This was not provided.

Your hospital claims that, since the patient in question went directly to the obstetrics department "as an outpatient clinic patient" rather than to the emergency room for her initial evaluation, she did not present to the emergency department, and thus deficiencies should not have been referenced to that department. It is our position that the Emergency Serv ices Condition of Participating (and the medical screening requirements of Section 1867) refer to any organized arrangement for the provision of unscheduled, urgent services, and are not intended to dictate a particular departmental structure. Indeed, Lincoln General properly instituted an emergency services record on this patient.

After considering the information provided by Lincoln General Hospital, it is our position that the State survey agency properly cited deficiencies in the Quality Assurance and Emergency Services Conditions of Participation. The State's finding that there was a violation of the "appropriate transfer" obligations of Section 1867 is affirmed, and it is noted that a physician also failed to certify that the benefits of the transfer in question outweighed the risks. Because of the good faith efforts made by the hospital to avoid a violation in this case, we believe that the gravity of the deficiency is mitigated. Our revised opinion is that the hospital is in substantial compliance, and we will not act immediately to terminate the provider agreement.

Lincoln General provides evidence that it has taken substantive actions to inform medical staff members of the COBRA transfer requirements and the steps being taken to assure the hospital's future compliance. These include a proposed amendment to the medical staff bylaws, a revised interhospital transfer form to assure certification by a physician that the risks of a transfer are outweighed by the benefits, and a broadened transfer protocol to cover all transfers, whether or not they originate in the emergency room. You provided copies of letters to other area hospitals with more advanced neonatal intensive care services, proposing interhospital patient transfer agreements. Further, you describe a recent case (June 7, 1989) to illustrate protracted, but successful attempts to secure an appropriate transfer for a high-risk premature infant.

In our opinion, the measures already underway at Lincoln General Hospital should be sufficient, when fully implemented, to safeguard against further violations of Section 1867. Therefore, the hospital will retain its "deemed status" and will not be subject to a full survey by the State agency. In order to verify the success of the corrective action, the State will perform a limited follow-up survey in approximately two months. Of course, the hospital will be expected to maintain compliance with all the Medicare Conditions of Participation.

Sincerely,

Kenneth C. Schneider, M.D.
Associate Regional Administrator
for Health Standards and Quality

cc:
Ricardo M. Guevara
Normand F. Pizza
bcc:
M. Chunn
official/reading files
KcS/JDS/JJP
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APPENDIX D

(Excerpt of transcript in trial court made a part of Appendix of Virginia Supreme Court.)

each point. I know Your Honor is busy. But, it seems to me that their major point is that indigency has to be alleged. I think the cases that we have cited take care of that. The second point they make is the transfer has to be from an emergency room to another hospital. The facts in this case are that this lady's water broke, she was premature, she was about 33 weeks pregnant approximately, that her water broke at 3:00 in the morning. She's 28 years old. She called her doctor and told her doctor she was going to a hospital. It was not her first baby. She knew what to do when her water broke. And she knew it was a serious matter. She went in the hospital. <u>They have a policy at Richmond Memorial Hospital that everybody who is 20 weeks or more pregnant goes to the labor and delivery room. She</u>

went in to the emergency room, but just walked through, if you will, because they take them directly to labor and delivery. And she stayed in labor and delivery then the entire day. And then she went back to labor and delivery later when she was transferred -- she was transferred, as I understand the facts now as I look at it, and understand no evidence has been taken in this case, there has been no discovery, there have been no depositions taken, our information comes from our client and from the medical records that we reviewed prior to filing this action. But, it appears based on the medical records that she was wheeled to the labor and (emphasis added).

FILING AND MAILING CERTIFICATE

I hereby certify that on this 2nd day of October, 1992, I filed 40 copies of a Brief in Opposition to the Petition for Writ of Certiorari the Clerk's Office of the Supreme Court of the United States and further certify that I mailed via first class mail, postage prepaid, the required three (3) copies to Judith B. Henry, Crews and Hancock, 700 East Main Street, Suite 1015, P.O. Box 1474, Richmond, Virginia 23212-1474. The necessary filing and mailing was performed in accordance with the instructions given me by counsel in this case.

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No. 92-421

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

RICHMOND MEMORIAL HOSPITAL,

Petitioners,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

On Petition for Writ of Certiorari to the Supreme Court of Virginia

MOTION FOR LEAVE TO FILE AND BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

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Connie Elizabeth Smith, and CONNIE
ELIZABETH SMITH, *individually*,
Respondents.

On Writ of Certiorari to the Supreme Court of Virginia

MOTION FOR LEAVE TO FILE BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF RESPONDENTS

The American Hospital Association ("AHA") respectfully moves the Court for leave to file a brief *amicus curiae* in support of the Petitioner Richmond Memorial Hospital.

The American Hospital Association has an interest in this case because the scope of coverage of the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd, affects the AHA's approximately 5400 hospital members,

many of whom are Medicare providers. EMTALA requires Medicare hospitals to fulfill certain obligations to individuals with emergency conditions. The Virginia Supreme Court has interpreted this federal act in a manner that broadly expands its scope of coverage to include all admitted patients at a hospital who develop emergency conditions. As a principal spokesman for American hospitals, the AHA can provide the Court with information relevant to the effect of the *Richmond Mem.* decision upon hospital operations nationwide.

Undersigned counsel for AHA has attempted to obtain consent to the filing of this brief pursuant to Supreme Court Rule 37.2. Counsel for Petitioners has given such consent but counsel for Respondents has indicated that Respondents will not consent.

WHEREFORE, AHA moves that this Court allow the filing of the "Brief of Amicus Curiae American Hospital Association In Support of Petitioner Richmond Memorial Hospital," which is submitted herein with the requisite number of printed copies.

Respectfully submitted,

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October 5, 1992

QUESTION PRESENTED

The first issue raised by the Petition and upon which the American Hospital Association submits this Brief Amicus Curiae is:

Whether the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd, imposed on Medicare hospitals to screen, and if appropriate, stabilize or transfer a patient coming to the emergency department also apply to such patient after stabilization or to a hospital patient not admitted through the emergency department?

TABLE OF CONTENTS

Page

MOTION FOR LEAVE TO FILE i

QUESTION PRESENTED iii

TABLE OF AUTHORITIES vii

INTEREST OF THE AMICUS CURIAE 1

SUMMARY OF ARGUMENT 4

ARGUMENT IN SUPPORT OF GRANTING THE WRIT 5

I. TO ELIMINATE FURTHER INCONSISTENT APPLICATION OF FEDERAL REQUIREMENTS FOR HOSPITAL EMERGENCY DEPARTMENTS THIS COURT SHOULD REVIEW THE VIRGINIA SUPREME COURT'S DECISION 5

II. THE VIRGINIA SUPREME COURT DECISION IMPROPERLY EXPANDS THE LIMITED FEDERAL OBLIGATION OF MEDICARE HOSPITALS TO PROVIDE EMERGENCY DEPARTMENT ACCESS 8

A. The Plain Language Of EMTALA Creates A Cumulative Requirement For An Emergency Department Screening, Stabilization Or Transfer 11

B. The Legislative History Confirms That Congress Intended To Impose EMTALA Requirements Only To The Extent Necessary To Ensure Access To Hospital Emergency Departments For Emergency Treatment 13

III. THE VIRGINIA SUPREME COURT DECISION WILL SIGNIFICANTLY AND ADVERSELY AFFECT HOSPITALS 16

A. The Virginia Court's Interpretation of EMTALA Disrupts Traditional Clinical Relationships And Responsibilities 16

B. The Virginia Court's Decision Undermines State Tort Reform. 18

CONCLUSION 20

TABLE OF AUTHORITIES

Page

Cases

Brooker v. Desert Hosp. Corp., 947 F.2d 412 (9th Cir. 1991) 11
Brooks v. Maryland General Hosp., Civ. A. No. HAR-91-2819, 1992 WL 142690 (D. Md. 1992) 7
Collins v. De Paul Hosp., 963 F.2d 303 (10th Cir. 1992) 7
Daniels v. Wills Eye Hosp., No. CIV. A. 91-2309, 1992 WL 103009 (E.D. Pa. May 7, 1992) 6
Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302 (N.D. Ill. 1990) 6, 8
Delaney v. Cade, 756 F. Supp. 1476 (D. Kan. 1991) 11
Di Gicomo v. St. Joseph's Hosp., 582 N.Y.S. 2d 887 (App. Div. 1992) 7
Evitt v. University Heights Hosp., 727 F. Supp. 495 (S.D. Ind. 1989) 7
Gatewood v. Washington Healthcare Corp., 933 F.2d 1037 (D.C. Cir. 1991) 7
HCA Health Servs. v. Gregory, 596 N.E.2d 974 (Ind. App. 1992) 7
Helton v. Phelps, 794 F. Supp. 332 (E.D. Mo. 1992) . . 6, 7
Hillsborough County, Florida v. Automated Med. Labs., Inc., 471 U.S. 707 (1985) 17
Johnson v. University of Chicago Hosp., 774 F. Supp. 510 (N.D. Ill. 1991) 6

TABLE OF AUTHORITIES -- Continued

Loss v. Song, No. 89C 6952, 1990 WL 159612 (N.D. Ill. Oct. 16, 1990) 6
Mastro Plastics Corp. v. NLRB, 350 U.S. 270 (1956) . . . 13
Power v. Arlington Hosp., No. CIV. A. 92-0005-A, ___ F. Supp. ___, 1992 WL 210588 (E.D. Va. Aug. 28, 1992) 7, 8
Richards v. United States, 369 U.S. 1 (1962) 13
Smith v. Richmond Mem. Hosp., 243 Va. 445, 416 S.E.2d 689 (1992) . . . . . passim
Stuart Cir. Hosp. Corp. v. Curry, 173 Va. 136, 3 S.E.2d 153 (1939) 10
Teufel v. United States, No. 89-1272-K, 1992 WL 160908 (D. Kan. June 15, 1992) 6
Thornton v. Southwest Detroit Hosp. Corp., 895 F.2d 1131 (6th Cir. 1990) 7, 11
United States v. Boisdoré's Heirs, 50 U.S. (8 How.) 113 (1850) 13
Walling v. Allstate Ins. Co., 183 Mich. App. 731, 455 N.E.2d 736 (1990) 10

Federal Statutes and Regulations

Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82 (1986) 2, 14
Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (1988) . . . . . *passim*
42 U.S.C. § 1395dd(a) . . . . . *passim*
42 U.S.C. § 1395dd(b) . . . . . *passim*
42 U.S.C. § 1395dd(c) . . . . . *passim*

TABLE OF AUTHORITIES – Continued

42 U.S.C. § 1395dd(d) 3
42 U.S.C. § 1395dd(e) 2
Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(a), 103 Stat. 2106 (1989) 12
Notice of Proposed Rulemaking, 53 Fed. Reg. 22,513 (1988) 3, 5

State Statutes

Cal. Bus & Prof. Code §§ 2000-2504 (West 1990 & Supp. 1992) 17
Cal. Health & Safety Code §§ 1250-1339.67 (West 1990 & Supp. 1992) 17
Ill. Rev. Stat. ch. 111, ¶¶ 4400-1 to -63 (1991) 17
Ill. Rev. Stat. ch. 111½, ¶¶ 142-57 (1991) 17
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N.Y. Pub. Health Law §§2800-2813 (McKinney 1985 & Supp. 1991) 17
Va. Code Ann § 8.01-581.2(A) (1992) 18

Legislative History

131 Cong. Rec. 28568 (1985) 9
131 Cong. Rec. 28569 (1985) 10, 15
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TABLE OF AUTHORITIES – Continued

131 Cong. Rec. 29824 (1988) 15
131 Cong. Rec. 29825 (1988) 14, 15
131 Cong. Rec. 29829 (1985) 10
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H.R. 3128, 99th Cong., 1st Sess. (1985) 14, 15
H. Rep. No. 241, 99th Cong., 1st Sess,
Pt. 1 (1985), *reprinted in* 1986
U.S.C.C.A.N. 579 . . . . . 13, 14, 15
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U.S.C.C.A.N. 726 15
S. Rep. No. 146, 99th Cong., 1st Sess
(1985), *reprinted in* 1986 U.S.C.C.A.N. 42 . . . . . 15, 18

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(1991-92 ed.) 16
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BRIEF OF THE AMERICAN HOSPITAL ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PETITIONER

INTEREST OF THE AMICUS CURIAE

The American Hospital Association ("AHA") is the primary national membership organization for hospitals in this country. It has approximately 5400 member hospitals and other health care organizations. AHA's principal objective is to promote high-quality health care and health services for all, through leadership and assistance to hospitals and health care organizations in meeting the health care needs of their communities.

Virtually all AHA acute care hospitals provide emergency room services and are participants in the federal Medicare program. As participants in the program, they are subject to EMTALA.[1] As the front line providers of emergency medical care, they are directly and significantly affected by its requirements. Under the Virginia Supreme Court's decision, *Smith v. Richmond Mem. Hosp.*, 243 Va. 445, 416 S.E.2d 689 (1992), EMTALA may now affect all patient transfers and discharges.[2]

AHA and its members are committed to assuring that individuals with emergency conditions[3] have access to emergency medical care through hospital emergency departments. An

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[1]This Brief uses the term EMTALA to refer to the obligations imposed upon Medicare hospitals by 42 U.S.C. § 1395dd (1988). Other courts, including the court below, use the term COBRA because EMTALA was adopted as part of the Consolidated Omnibus Budget Reconciliation Act of 1985. As COBRA contains many unrelated provisions, use of the term EMTALA helps to focus on the specific legislation relating to Medicare hospital emergency departments' responses to individuals with emergency conditions. Unless indicated otherwise, citations to EMTALA refer to the statute as it existed in 1988, the date of the events in the underlying action.

[2]As defined in EMTALA, a "transfer" includes a discharge. 42 U.S.C. § 1395dd(e)(5). All transfers of patients with unstabilized emergency conditions must follow the subsection (c) protocols. *Id.* § 1395dd(b).

[3]For purposes of this Brief, the term "emergency condition" means both "emergency medical condition" and "active labor," as those terms were defined in 1988. In 1988 EMTALA referred to "emergency medical condition" and "active labor" in separate definitional sections. 42 U.S.C. § 1395dd(e)(1 & 2) (1988). Congress later amended EMTALA to merge the terms into one definitional concept "emergency medical condition" that incorporates the 1988 subsection (e)(1) definition of emergency medical condition and a modified version of the 1988 subsection (e)(2) definition of active labor. 42 U.S.C. § 1395dd(e)(1)(A & B)(1988 & Supp. I 1989).

emergency department's refusal to provide emergency treatment to a person with an emergency condition is a matter of serious concern and is dealt with severely under EMTALA. A hospital can be fined, lose the right to payment for treating Medicare beneficiaries, and be sued in a civil damages action. 42 U.S.C. § 1395dd(d). The federal investigative process is swift and public. *See* Notice of Proposed Rulemaking, 53 Fed. Reg. 22,513, 22,518 (June 16, 1988) (expressing federal enforcement agency's intent to follow the fast-track termination process). It has been and continues to be of concern to AHA and its members that a statute with such serious implications be administered clearly, fairly, and faithfully to the intent of Congress.

In the absence of interpretive federal regulations, on behalf of its member hospitals, AHA sought the views of the Health Care Financing Administration ("HCFA") of the Department of Health and Human Services, the federal agency charged with enforcement of EMTALA. With the benefit of HCFA's views, AHA prepared a briefing to its members on the requirements of EMTALA. The Virginia Supreme Court's conclusion that the EMTALA transfer protocols apply to the inpatient[4] setting regardless of contact with the emergency department is inconsistent with both AHA's understanding of the reach of the statute and the interpretation HCFA follows in enforcing the statute. As a result, AHA members who followed the federal agency's interpretation of EMTALA may now face different legal liabilities from private actions and from administrative enforcement of the act. Consequently, the Virginia Supreme Court's decision undercuts fair and uniform enforcement of EMTALA. Further, AHA member hospitals now face new risks

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[4]For purpose of the discussion in this Brief, the term "inpatient" refers to a patient admitted for a hospital stay and treatment upon the order of an admitting physician. In contrast, there are countless patient visits to a hospital's emergency department and for outpatient services which do not result in an admission. These patients would not be considered "inpatients."

of liability for treatment settings and decisions never addressed by Congress in enacting EMTALA. With litigation proceeding across the country in state and federal courts, the risk of inconsistent and contrary imposition of liability on AHA member hospitals increases as a result of the Virginia Supreme Court ruling.

SUMMARY OF ARGUMENT

This Court should grant the petition and determine that the EMTALA requirements for Medicare hospitals to screen, and if appropriate, stabilize or transfer apply only to a patient that presents to the emergency department in an emergency condition. The Court should reverse the holding below that an inpatient not admitted to a Medicare hospital through the emergency department may seek EMTALA damages. In addition, this Court should affirm Congress's intent that EMTALA obligations terminate once a Medicare hospital stabilizes an emergency condition.

Only this Court can authoritatively resolve the proper scope of this federal statute. The Virginia court's overbroad interpretation of EMTALA directly conflicts with the federal enforcement agency's interpretation and has spawned further confusion among the courts applying the statute. If left unresolved, this conflict will prolong the uncertainty faced by Medicare hospitals that have followed federal agency guidance but now may have broader liability in private damage actions. Neither a plain reading of the statute, nor its legislative history support the conclusion of the *Richmond Mem.* court. EMTALA should be interpreted to impose a series of related requirements linked to the presentment of a person with an emergency condition at a Medicare hospital emergency department.

Determining when the Act's obligations begin and end will ensure that EMTALA fulfills its purpose without excessive intrusion into traditional state law responsibilities for and

regulation of the delivery of medical care. The *Richmond Mem.* decision threatens to dislocate the traditional treatment relationships among inpatients, their admitting physicians, and hospitals. This Court should provide guidance at this time to restrain legal interpretations of EMTALA that would convert its provisions into a federal malpractice statute, bypassing state efforts to reform tort law.

ARGUMENT IN SUPPORT OF GRANTING THE WRIT

I. TO ELIMINATE FURTHER INCONSISTENT APPLICATION OF FEDERAL REQUIREMENTS FOR HOSPITAL EMERGENCY DEPARTMENTS THIS COURT SHOULD REVIEW THE VIRGINIA SUPREME COURT'S DECISION.

EMTALA is an important federal statute, intended to assure that individuals with emergency medical conditions have access to emergency medical treatment at hospital emergency departments. The decision of the Virginia Supreme Court may make every hospital patient's medical stabilization, transfer or discharge subject to EMTALA. The Virginia court's interpretation of EMTALA raises solely a federal question. The potential impact of the Virginia court's decision makes it imperative that this Court intervene now and construe EMTALA's scope and application.

This Court also should accept the Petition to resolve a conflict between the Virginia court's interpretation of EMTALA and the interpretation applied by HCFA. HCFA has consistently interpreted the requirements of EMTALA to apply to the emergency department of a hospital. *See* Notice of Proposed Rulemaking, 53 Fed. Reg. at 22,518-19 (June 16, 1988) (discussing application of the screening, stabilization and transfer requirements in the context of a person presenting for emergency services). HCFA has repeatedly confirmed its position that EMTALA applies to the emergency department and has made clear that its application ends at the point the individual is

stabilized. Pet. Br. App. H-4 to H-5 (1990)(responding to AHA inquiry at App. G-8 to G-9); App. E-6, E-14 to E-15 (1992)(HCFA instructions to State Agencies regarding enforcement of EMTALA). Hospitals which have relied on HCFA's interpretation are now placed at risk of additional liability under *Richmond Mem.* The effect of the decision is to create parallel but inconsistent requirements for hospital compliance with EMTALA under the private action and administrative enforcement provisions.

Imposing liability in a private action where there has been no patient contact with the emergency department also is inconsistent with the holdings of other jurisdictions. In reviewing the Act, several courts have indicated that the plaintiff must allege presentment to the emergency department. *E.g.*, *Johnson v. University of Chicago Hosp.*, 774 F. Supp. 510, 513 (N.D. Ill. 1991)(EMTALA claim dismissed because plaintiff did not come to emergency room of hospital); *Daniels v. Wills Eye Hosp.*, No. CIV. A. 91-2309, 1992 WL 103009 (E.D. Pa. May 7, 1992)(all EMTALA claims dismissed because plaintiff could not allege that he presented to an emergency department of hospital). *See Teufel v. United States*, No. 89-1272-K, 1992 WL 160908, *4-*5 (D. Kan. Jun. 15, 1992)(rejecting *Richmond Mem.* in context of long-term psychiatric treatment); *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990)(essential element of § 1395dd(b) claim is that plaintiff presented to emergency department of hospital). *But see Helton v. Phelps*, 794 F. Supp. 332, 333 (E.D. Mo. 1992); *Loss v. Song*, No. 89C 6952, 1990 WL 159612 (N.D. Ill. Oct. 16, 1990)(child born after mother came to emergency room entitled to bring EMTALA claim).

Acceptance of the Petition would reduce inconsistency and confusion among the courts on other issues of EMTALA

interpretation.[5] A decision by this Court on the scope and application of EMTALA would bring clarity to the threshold issue in all cases -- when does EMTALA afford a private right of action. Uniform application would be assisted if this Court accepted the Petition and determined whether EMTALA's requirements only afford persons with emergency conditions access to emergency departments for emergency medical treatment.

Until reviewed by this Court, *Richmond Mem.* will control private actions in Virginia state courts and will be used as persuasive authority in other state and federal courts. It has already been cited with approval in one case holding that a cause of action for EMTALA can arise without presentation at the emergency room, *Helton v. Phelps*, 794 F. Supp. at 333, and in several others negating application of provisions of state medical malpractice acts[6] deemed to conflict with EMTALA. *HCA Health Servs. v. Gregory*, 596 N.E.2d 974 (Ind. App. 1992), *Power v. Arlington Hosp.*, No. CIV. A. 92-0005-A, ___ F. Supp.

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[5]Litigation of key aspects of EMTALA has resulted in a variety of conflicting, inconsistent, and thus confusing interpretations. Some courts require a demonstration that the hospital's action was influenced by the indigence or economic circumstances of the individual, *see, e.g., Evitt v. University Heights Hosp.*, 727 F.Supp. 495 (S.D. Ind. 1989), *Di Gicomo v. St. Joseph's Hosp.*, 582 N.Y.S. 2d 887 (App. Div. 1992); others do not, *see, e.g., Brooker v. Desert Hosp. Corp.*, 947 F.2d 412 (9th Cir. 1991), *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037 (D.C. Cir. 1991), *Collins v. DePaul Hosp.*, 963 F.2d 303 (10th Cir. 1992). One has considered treatment as an inpatient to satisfy a hospital's obligation, *Collins v. DePaul Hosp.*, 963 F.2d at 308, another has required more, *Thornton v. Southwest Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990).

[6] One federal district court has reached the opposite conclusion. *Brooks v. Maryland Gen. Hosp. Inc.*, Civ. A. No. HAR-91-2819, 1992 WL 142690 (D. Md. 1992) (applying Maryland malpractice act requirements to EMTALA claim).

___, 1992 WL 210588, at *5 (E.D. Va. Aug. 28, 1992). Resolution of the threshold issue by this Court would conserve judicial and health care resources that would otherwise be expended in litigation in state and federal courts, and would assure uniformity in the interpretation of the respective rights and obligations under EMTALA for patients, hospitals, and physicians throughout the country.

II. THE VIRGINIA SUPREME COURT DECISION IMPROPERLY EXPANDS THE LIMITED FEDERAL OBLIGATION OF MEDICARE HOSPITALS TO PROVIDE EMERGENCY DEPARTMENT ACCESS.

EMTALA created a limited obligation requiring Medicare hospitals to respond to any individual seeking treatment at a hospital emergency department. To comply with EMTALA, the emergency department must screen the individual and determine if the individual has an emergency condition. 42 U.S.C. § 1395dd(a). If an emergency condition exists, the hospital must either stabilize the person's condition or[7] transfer the person using EMTALA procedures. 42 U.S.C. § 1395dd(b)(1)(A & B) & (c). Notwithstanding these limited statutory requirements, the *Richmond Mem.* court held that a hospital could be liable under EMTALA for civil damages to an inpatient who had not presented to the hospital emergency department. 243 Va. at 454-55, 416 S.E.2d at 694.

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[7]Some courts have misread EMTALA to create an obligation to stabilize before transfer. *Deberry v. Sherman Hosp. Ass'n*, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990) (to state an EMTALA claim, would-be plaintiff may allege that hospital transferred him before stabilizing the emergency condition). Yet the statutory requirement clearly is disjunctive: "[T]he hospital must provide *either* (A)[stabilization] *or* (B)[transfer pursuant to the provisions of subsection 1395dd(c)]. 42 U.S.C. § 1395dd(b)(1) (emphasis added).

On its face, EMTALA establishes a unitary set of requirements through subsections (a), (b), and (c), which are cumulative in nature. 42 U.S.C. § 1395dd(a-c). In marked contrast to the statute's terms, the Virginia Supreme Court held that "each subsection [of EMTALA] describes distinct patient circumstances requiring different treatment protocols." 243 Va. at 451, 416 S.E.2d at 692. The *Richmond Mem.* court found "nothing in [EMTALA] which limits application of these subsections [b and c] solely to a patient who initially arrives at an emergency room and who has not been stabilized." *Id.* at 452, 416 S.E.2d at 692. The court acknowledged, however, that "the legislative history of [EMTALA] indicates Congressional concern with denial of treatment and inappropriate transfers of indigent *persons who come to the emergency rooms*," *id.* at 454, 416 S.E.2d at 693-94 (emphasis added). Yet the court held that "the plain language Congress chose does not limit the Act to those circumstances." *Id.* at 454, 416 S.E.2d at 694.

Consequently, *Richmond Mem.* imposes on all hospitals in Virginia increased requirements and liability under a federal statute for patient care unrelated to emergency department screening and stabilization. Neither EMTALA's text nor its legislative history support the *Richmond Mem.* holding. As further demonstrated below, this Court should review the Virginia Supreme Court's ruling to assure consistent and appropriate application of the rights and remedies created by Congress to assure access to emergency care.

Congress created EMTALA as a specific remedy for a significant but discrete problem: the refusal by some hospital emergency rooms to assist indigent individuals with emergency conditions. "[EMTALA] addresses an issue which has gained much public attention over the last year. . . . [T]he inappropriate transfer of a number of seriously ill patients *from the emergency rooms of private hospitals to public hospitals*." 131 Cong. Rec. 28568 (Oct. 23, 1985) (Sen. Durenberger) (emphasis added). Many states did not require hospitals to respond to requests for

emergency assistance. *See, e.g., Walling v. Allstate Ins. Co.*, 183 Mich. App. 731, 735, 455 N.W.2d 736, 738 (1990) (describing traditional common law rule). Congress concluded that in a number of states there was no statutory, regulatory, or common law requirement to treat patients coming to a hospital emergency department. "Some states have laws which ensure that no emergency patient is denied emergency care because of inability to pay. But, 28 states have no such law." 131 Cong. Rec. 28569 (Oct. 23, 1985) (Sen. Kennedy). Both the hospital and the doctor in such states were free to decline treatment, even in admittedly emergent circumstances such as trauma or active labor.

To close this perceived gap in state law, Congress crafted EMTALA subsections (a) and (b)

> to require[ ] hospital emergency departments to medically screen and stabilize any patient seeking medical attention from the emergency department.

131 Cong. Rec. 29829 (Oct. 31, 1985) (remarks of Congressman Stark). Thus, EMTALA compels Medicare hospital emergency departments to conduct an appropriate medical screening of all individuals seeking emergency care to determine if an emergency condition exists. If an emergency condition is identified, the hospital must then treat the patient to stabilize the condition or transfer the patient. Transfer in such cases must comport with the protocols set forth in subsection (c). By these cumulative provisions all persons have access to initially responsive treatment for emergency conditions.

EMTALA, however, plainly does not govern treatment of inpatients already afforded access to a hospital. After admission to a hospital, patients do not need the EMTALA guarantees of access to screening and stabilization because they have a common law remedy if such treatment is negligent. *See Stuart Cir. Hosp. Corp. v. Curry*, 173 Va. 136, 147-52, 3 S.E.2d 153, 157-59 (1939). Only one type of patient needs and has EMTALA

protection: a person who presented to the emergency department with an emergency condition. *Thornton v. Southwest Detroit Hosp. Corp.*, 895 F.2d at 1134. Moreover, once the hospital stabilizes an emergency condition, the hospital has met its EMTALA duties. *Id.*; *Brooker v. Desert Hosp. Corp.*, 947 F.2d at 415; *Delaney v. Cade*, 756 F. Supp. 1476, 1485-87 (D. Kan. 1991). Thereafter, other regulatory and common law duties may apply; but, the "gap" perceived by Congress is closed when the emergency condition has been screened in the emergency department and the person stabilized or transferred, if appropriate.

A. The Plain Language Of EMTALA Creates A Cumulative Requirement For Emergency Department Screening, Stabilization Or Transfer.

Plainly read, the provisions of section 1395dd mandating access to emergency care are not severable. Subsection (a) creates the duty to determine by medical screening whether any patient coming to the emergency department requires treatment for an emergency condition. Then, and only if such emergency condition is found, subsection (b) creates a duty to "treat" by stabilizing or transferring the patient in accordance with EMTALA directives. If the hospital intends to transfer, under subsection (c) it must get an appropriate consent from the patient or document the emergency physician's "certification" of the medical necessity for transfer and consent of the receiving hospital.

The Virginia Supreme Court ignored the statutory context of these interrelated and interdependent provisions of EMTALA. It allowed plaintiff Smith to pursue her claims that Richmond Memorial Hospital failed to stabilize her condition as required by subsection (b) and, alternatively, failed to transfer her in accordance with the transfer protocols of subsection (c). Yet, the provisions of § 1395dd are triggered when an individual seeking care appears at the emergency department. The department then "must provide for . . . an appropriate medical screening . . . to

determine" if an emergency condition exists. 42 U.S.C. § 1395dd(a). Plaintiff Smith apparently was admitted to Richmond Memorial Hospital by her regular obstetrician and, therefore, she did not allege that she had received a screening from Richmond Memorial Hospital's emergency department.[8] The hospital's subsection (b) obligation to stabilize or transfer plaintiff Smith would arise only if an emergency department subsection (a) screening was sought and disclosed an emergency condition.

Contrary to the Virginia opinion, subsection (b) does not independently compel the hospital to make a determination; it merely describes what the hospital must do *if* a determination has been made, *i.e.*, stabilize or transfer.[9] Unlike subsection (a), subsection (b) does not require the hospital to arrive at a determination.

The Virginia Supreme Court does not explain why the stabilization requirement would exist independently of the screening determination. Moreover, if subsection (b) were read

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[8] In addition, Ms. Smith's claim fails because she conceded that, after her admission on July 18, 1988, Richmond Memorial Hospital "treated and stabilized her." Pet. Br. at 7-8 (citing Tr. 44 of Trial Court's Hearing on the Demurrer).

[9] The change from "emergency department" in subsection (a) to "hospital" in subsection (b) is the sole basis for the *Richmond Mem.* interpretation that subsections (a), (b) and (c) describe "distinct patient circumstances requiring different treatment protocols." 243 Va. at 451, 416 S.E.2d at 692. A more plausible reading would be that the change in terms expressed Congress's intent that the emergency department may need to use other hospital departments and resources to screen, stabilize or transfer patients coming to the emergency department. This reading is supported by later amendments compelling the hospital to use all of its resources that are reasonably available to respond to an emergency condition. *E.g.*, Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6211(a), 103 Stat. 2106, 2245 (1989), amending 42 U.S.C. § 1395dd(a).

in isolation to create "a different treatment protocol," as *Richmond Mem.* holds, 243 Va. at 451, 416 S.E.2d at 692, its requirements would not be limited to Medicare hospitals, nor even to hospitals with emergency departments. Finally, because subsection (b) does not independently impose any duty to conduct a medical screening, under the Virginia court's analysis a hospital simply could refuse to make a determination and avoid liability under EMTALA entirely.

Clearly, such results would be contrary to the express language of the Act read as a whole. And courts must read a statute as a whole in a manner that gives effect to the intent of the legislature. *Richards v. United States*, 369 U.S. 1, 11 (1962) (quoting *Mastro Plastics Corp. v. NLRB*, 350 U.S. 270, 285 (1956) (quoting *United States v. Boisdoré's Heirs*, 50 U.S. (8 How.) 113, 122 (1850))). Only by reading the plain language of subsections (a), (b)(1), and (c) as related and cumulative requirements does EMTALA mandate that Medicare hospital emergency departments afford appropriate medical screening and treatment.

B. The Legislative History Confirms That Congress Intended To Impose EMTALA Requirements Only To The Extent Necessary To Ensure Access To Hospital Emergency Departments For Emergency Treatment.

The legislative history of EMTALA confirms that Congress intended to assure all persons coming to an emergency department an appropriate medical screening and, if necessary, stabilization or transfer. The contemporaneous Ways & Means Committee Report, H. Rep. No. 241, 99th Cong., 1st Sess., pt. 1, at 4 ("H. Rep., pt. 1") (July 31, 1985), *reprinted in* 1986 U.S.C.C.A.N. 579, 582, irrefutably establishes the intent in its explanation of subsection (b):

> Necessary Stabilizing Treatment.-- Within their capacities, hospital *emergency departments* must provide appropriate treatment *to stabilize* patients who have emergency medical

> conditions and to provide treatment for patients in active labor, *or provide for appropriate transfers*.

131 Cong. Rec. 29825 (Oct. 31, 1985) (emphasis added)[10]. This early language clearly establishes that the Committee always intended that subsection (b) would be a continuation of the EMTALA requirement that begins with the emergency department screening. Subsection (b) was not intended to impose an independent obligation for the hospital to constantly determine if an emergency condition existed for every patient admitted to the hospital. (Yet, this is the effect of the Virginia opinion.) Rather subsection (b) complements the screening provision by assuring that emergency conditions identified by the screening are treated through stabilization or a transfer in accordance with the subsection (c) protocols.

Legislative history also establishes that EMTALA's requirements are directed to the hospital emergency department. The Judiciary Committee's comments on the proposed EMTALA provisions presuppose that the screening and the stabilization or transfer obligation imposed by the bill applied *only* to hospitals with emergency medical departments.

> [S]ome hospitals, particularly those located in rural or poor areas, may decide to close their emergency rooms entirely rather than risk the [bill's proposed] civil fines, damage awards, and as to physicians, criminal penalties that might ensue.

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[10]Section 1395dd first appeared as § 124(b) in H.R. 3128, 99th Cong., 1st Sess. (1985), with its accompanying H. Rep. No. 241, pt. 1, at 3-4, 27-28, 131-134, from the House Ways and Means Committee. In the various bills pending during 1985-86, as in the Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, 100 Stat. 82, 164 (Apr. 7, 1986), the EMTALA § 1395dd provisions appear under § 1867, referring to its enumeration in the Social Security Act.

H. Rep. 241, 99th Cong., 1st Sess., pt. 3, at 6 (Sept. 11, 1985), *reprinted in* 1986 U.S.C.C.A.N. 726, 728.[11] Yet, by focusing on subsection (b) in isolation the Virginia opinion would extend EMTALA to all hospitals.

The Senate history also reveals the narrow focus of the legislation upon emergency treatment. "The bill does not create an obligation of any hospital to treat any patient *except in an emergency situation* and does not interfere with the practice of medicine." S. Rep. No. 146, 99th Cong., 1st Sess. 454 (Oct. 2, 1985), *reprinted in* 1986 U.S.C.C.A.N. 42, 413 (emphasis added). The Senators stated on the floor that the provisions regulated emergency room treatment.

> [EMTALA] would enable the Secretary of Health and Human Services to terminate a hospital from the Medicare program that has inappropriately transferred or "dumped" a patient *from* its emergency room.

131 Cong. Rec. 28569 (Oct. 23, 1985) (Sen. Heinz) (emphasis added). No Senator suggested that the bill would regulate

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[11]The comments during the House debate also indicate an understanding that the proposed EMTALA requirements would apply only to the emergency room operations of hospitals. The Ways and Means Committee had placed in the Record its "Detailed Description of H.R. 3128" with "a more detailed description of the Medicare and public assistance provisions [Title I]". 131 Cong. Rec. 29822, 29823, 29824 (Oct. 31, 1985). This "more detailed description" repeated the explanation from the Ways and Means Committee Report, H. Rep. No. 241, pt. 1, that subsection (b) applied only to hospital emergency departments. *Compare* 131 Cong. Rec. 29825 (Oct. 31, 1985) *with* H. Rep. No. 241, pt. 1, at 4, *reprinted at* 1986 U.S.C.C.A.N. at 582, *supra* p. 13-14. The text of subsection (b) in the October 31, 1985 version of H.R. 3128 as adopted on the House floor the same day exactly matches the text of § 1395dd(b)(1) as adopted in the final version on March 1986. 131 Cong. Rec. 29846 (Oct. 31, 1985).

stabilization or transfer of patients unrelated to emergency department care.

Taken as a whole, the legislative history and the statutory text confirm that EMTALA imposes a specific continuous and cumulative obligation. Patients who do not arrive through the emergency department, or who have been stabilized after emergency department screening, simply are not within the zone of patient interests protected by EMTALA. In contradiction to the overwhelmingly consistent legislative intent, however, the *Richmond Mem.* court has held that a patient who was admitted to a hospital by her physicians, and apparently not as result of seeking treatment in the emergency department, may pursue EMTALA damages. Faced with this Virginia Supreme Court ruling, all of Virginia's hospitals, and the hospitals of any other state that adopts this ruling, must struggle to understand and apply EMTALA's requirements in virtually every hospital treatment setting.

III. THE VIRGINIA SUPREME COURT DECISION WILL SIGNIFICANTLY AND ADVERSELY AFFECT HOSPITALS.

A. The Virginia Court's Interpretation of EMTALA Disrupts Traditional Clinical Relationships And Responsibilities.

If applied to the inpatient setting, EMTALA will reach hundreds of thousands of treatment decisions made in the course of the routine operation of hospitals in transferring or discharging patients. During 1990, over 31 million individuals were admitted to community hospitals. American Hosp. Ass'n, *AHA Hospital Statistics* 20 (1991-92 ed.). The Virginia court's decision potentially imposes EMTALA requirements on all transfers or discharges relating to those patients.

Construing EMTALA as applicable to inpatient settings results in consequences unintended by Congress. The overlap between its provisions and already existing clinical and legal relationships will create unnecessary confusion regarding legal liability and treatment obligations. In contrast to the emergency department, where individuals arrive unaccompanied by a physician or without any personal physician, admission as an inpatient and their course of treatment is under the care and supervision of a physician who has privileges to admit and treat at the hospital. *See* Joint Comm'n on Accreditation of Hosps., *Accreditation Manual for Hospitals* 59 (1992) (Medical Staff Std. 2.16.5). Treatment decisions, including transfer and discharge, are the responsibility of this attending physician. An essential obligation of a hospital under the EMTALA transfer provision is to assure that a physician is involved in a decision to transfer. *See* 42 U.S.C. § 1395dd(c)(1)(A)(ii). For an inpatient, such a decision to transfer could only be made with the treating physician's authorization.

Applying EMTALA to the inpatient setting also would insert the federal government into the role of evaluating medical judgment and treatment decisions. A challenge to the transfer of an inpatient under EMTALA necessarily would include a review of the treating physician's judgment. The practice of medicine and the operation of hospitals, however, are adequately regulated under existing state agencies and accrediting organizations. *See, e.g.*, Cal. Health & Safety Code §§ 1250-1339.67, Cal. Bus. & Prof. Code §§ 2000-2504 (West 1990 & Supp. 1992); Ill. Rev. Stat. ch. 111 ½, ¶¶ 142-57, Ill. Rev. Stat. ch. 111, ¶¶ 4400-1 to -63 (1991); N.Y. Pub. Health Law §§ 2800-2813, N.Y. Educ. Law §§ 6520-6531 (McKinney 1985 & Supp. 1992). There is an existing body of state law establishing the respective rights and responsibilities in the patient/physician and patient/hospital relationships. Federal law has traditionally deferred to the states on such matters of health and public welfare. *Hillsborough County, Florida v. Automated Medical Labs., Inc.*, 471 U.S. 707(1985).

Superimposing EMTALA on the inpatient setting also would potentially subject disputes over inpatient transfer and discharge decisions to the federal administrative enforcement process. A HCFA investigation can be initiated on the basis of any complaint that a person's rights under EMTALA have been violated. Yet the Medicare Act is not intended to affect the practice of medicine or authorize its regulation. Section 1801 of the Medicare Act, 42 U.S.C. § 1395 (1988). The Report of the Senate Committee on Labor and Human Resources Report confirms that EMTALA was not intended to be an exception to this established principle of the Medicare Act. S. Rep. No. 146, 99th Cong., 1st Sess. 454 (1985), *reprinted in* 1986 U.S.C.C.A.N. at 413, *supra* p.15. Through its ongoing involvement with the Medicare program, Congress is familiar with the operations of hospitals and the routine relationship between inpatients and their physicians. Congress would not have made inpatient transfer disputes subject to HCFA investigations without leaving some legislative history of its intent to do so.

B. The Virginia Court's Decision Undermines State Tort Reform.

The Virginia Supreme Court's decision may also serve to frustrate accomplishment of state tort reform initiatives. *Richmond Mem.* has determined that the Virginia Malpractice Act's 90 day notice requirements, Va. Code Ann. § 8.01-581.2(A) (1992), do not apply to EMTALA claims. 243 Va. at 455-57, 416 S.E.2d at 694-95. Over the past 20 years virtually all states have enacted some tort reform measures. General Accounting Office, *Medical Malpractice: A Framework for Action* 8 (May, 1987). Reforms included statutory caps on noneconomic damages, prior notice requirements, shortened statutes of limitations, and prescreening panels. State tort reform efforts reflect the balance struck by state legislatures to deter and compensate for negligent acts in the delivery of health care while minimizing the adverse effects of broad-ranging malpractice liability upon the delivery of health care services. By applying

EMTALA to the transfer or discharge of inpatients, *Richmond Mem.* has extended the scope of issues subject to a private action to include the judgment of a treating physician in transferring or discharging his or her patient, thus blurring the distinction between EMTALA claims and negligence claims. By refusing to apply the state malpractice notice requirement, *Richmond Mem.* has isolated these federal challenges from the procedures that would otherwise apply. *Richmond Mem.* sets the stage for the use of EMTALA to litigate issues that clearly are intended to be the subject of a negligence action where state tort reform requirements would apply.

Applying EMTALA to the inpatient setting confuses the clinical and legal relationships of patients, their physicians, and hospitals. Nothing in the statutory text, the legislative history of the Act, or the *Richmond Mem.* analysis supports deviation from the longstanding principles and practices governing the treatment of inpatients.

CONCLUSION

The Virginia Supreme Court's disjointed reading of EMTALA should not remain a precedent further sowing seeds of confusion about the proper application of EMTALA. Congress adopted this law to fill a gap in existing state laws which often failed to assure access to emergency care. EMTALA is an important federal response to this discrete national problem; its clear terms and manifest intent should not be subject to disparate and conflicting interpretation by state courts.

Respectfully submitted,

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No. 92-421

IN THE
SUPREME COURT OF THE UNITED STATES
October Term, 1992

RICHMOND MEMORIAL HOSPITAL,

Petitioner,

v.

TAJA SMITH, an infant who sues by and through her next friend and mother, Connie Elizabeth Smith, and CONNIE ELIZABETH SMITH, individually,

Respondents.

On Petition For a Writ Of Certiorari To The Supreme Court Of Virginia

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SUPPLEMENTAL BRIEF

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TABLE OF CONTENTS

	Page
ARGUMENT	2
CONCLUSION	14

TABLE OF AUTHORITIES

Page

Cases:

Baber v. Hospital Corporation of America, ___ F.2d ___, 1992 WL 259249 (4th Cir. Oct. 7, 1992) 2-10

Daniels v. Wills Eye Hosp., No. Civ. A. 91-2309, 1992 WL 103009 (E.D. Pa. May 7, 1992) 11

Helton v. Phelps County Regional Medical Center, 794 F. Supp. 332 (E.D. Mo. 1992) 12

Johnson v. University of Chicago Hosps., ___ F.2d ___, 1992 WL 259404 (7th Cir. Oct. 7, 1992), *rev'g* 774 F. Supp. 510 (N.D. Ill. 1991) 10, 11, 12

Smith v. Richmond Mem. Hosp., 243 Va. 445, 416 S.E.2d 689 (1992) ..... *passim*

Statute:

42 U.S.C. § 1395dd ..... *passim*

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SUPPLEMENTAL BRIEF

Richmond Memorial Hospital ("the Hospital"),* by counsel, submits this supplemental brief in order to apprise the Court of authority decided since the filing of the Hospital's petition for a writ of certiorari which might well affect the Court's ruling on the petition.

ARGUMENT

On October 7, 1992, the United States Court of Appeals for the Fourth Circuit handed down a decision in Baber v. Hospital Corporation of America, ___ F.2d ___, 1992 WL 259249 (4th Cir. Oct. 7, 1992), interpreting the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA" or "the Act"), 42 U.S.C. § 1395dd (also known as the patient-dumping

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* The list of the Hospital's parent and subsidiary companies required by Rule 29.1 is contained in the Petition for Certiorari, at ii.

statute), as they relate to hospitals sued for damages under the Act. In contrast to the Supreme Court of Virginia's decision in the instant case, Smith v. Richmond Memorial Hospital, 243 Va. 445, 416 S.E.2d 689 (1992), reproduced in Appendix A to the petition for certiorari, which merely paid lip-service to application of the plain meaning rule of statutory interpretation (A-17 through 18, 25), the Fourth Circuit in Baber applied the plain meaning rule and refused to extend the requirements of EMTALA to hospital situations not addressed by the statute. 1992 WL 259249, * 11. As a result of the Baber decision, whether hospitals in Virginia face liability for damages under EMTALA in a treatment setting outside the emergency department may depend upon whether the

suit alleging violation of the Act is filed in state or federal court.

In Baber, a patient with a history of recurring psychiatric problems presented to the emergency room of Raleigh General Hospital ("RGH") with various complaints. The emergency room doctor examined her, ordered certain laboratory tests and administered medication in an attempt to calm her down. The patient, who was very agitated during her stay in the emergency room, experienced a seizure and fell and struck her head. The emergency room doctor again examined the patient, sutured a small laceration on her head, performed a blood gas study and watched her for focal neurological signs over a period of one hour. Believing that her seizure was related to her recurring psychiatric problems

and that she had not suffered a serious head injury as a result of the fall, and after discussing the situation with her attending physician, the emergency room doctor at RGH had the patient transferred to the psychiatric ward at Beckley Appalachian Regional Hospital ("BARH") where she had previously been treated. RGH did not have a psychiatric ward. 1992 WL 259249, at *2 - *3.

The patient was admitted directly to the psychiatric ward at BARH and was not processed through its emergency room. While the patient was checked every fifteen minutes by the nurses at BARH, she did not receive an initial screening examination. A few hours later she experienced another seizure and a CAT scan revealed a fractured skull and a subdural hematoma. She was transported back to RGH because that facility had a

neurosurgeon on staff and BARH did not have the facility or staff to treat serious neurological problems. Later that day she died as a result of a cerebral hemorrhage. Id. at *3.

A suit was filed, claiming inter alia that RGH had violated EMTALA by failing to provide an appropriate medical screening to discover that the patient had an emergency medical condition as required by § 1395dd (a) and by transferring her before her emergency medical condition had been stabilized and without completing the proper paperwork as required by §§ 1395dd (b) and (c). Id. at *5. It was also claimed that BARH violated EMTALA by failing to perform an appropriate medical screening upon the patient's admittance to its psychiatric unit. Id. at *11.

The Fourth Circuit held that RGH had satisfied the appropriate medical screening requirement of § 1395dd (a) by providing the patient with a screening examination which conformed with that which it would have performed on any patient in a similar condition. Id. at *6. The court further held that RGH had not violated EMTALA's transfer requirements, because these requirements attach only when the hospital has actual knowledge that the patient has an emergency medical condition and RGH had no such knowledge. Id. at *10 - *11. Finally, the court held that BARH had not violated EMTALA because a hospital's duty to provide an appropriate medical screening rises only where the patient seeks treatment from the hospital's emergency department. Id. at *11.

Unlike the Supreme Court of Virginia's holding in the instant case, the Fourth Circuit in Baber held that contact with the hospital's emergency room is necessary in order to invoke the requirements of EMTALA and that the duties created by EMTALA do not apply to all treatment settings within a hospital. Id. at *11. The Fourth Circuit declined the plaintiff's invitation to change the plain meaning of the statute "to require that hospitals provide an appropriate medical screening to all patients seeking treatment from any section or department of a hospital." Id. at *12. In contrast, the Supreme Court of Virginia in Smith v. Richmond Memorial Hospital accepted the plaintiff's invitation to change the plain meaning of the statute to apply EMTALA's transfer requirements to all patients receiving treatment from any

section or department of a hospital, by reading subsections (b) and (c) of § 1395dd out of context and wholly without reference to subsection (a).

As the Fourth Circuit stated, "EMTALA is designed to require hospitals to treat patients with emergency medical conditions by requiring hospitals to provide all patients with a basic evaluation to determine whether the patient has a serious or life threatening condition." Id. at *12. The court held, however, that this requirement of a basic evaluation applies only in the emergency room, not the inpatient setting. Id. at *11. Richmond Memorial's holding with respect to the applicability of EMTALA's transfer requirements to the inpatient setting appears to conflict, at least in principle, with the view of EMTALA articulated by the Fourth

Circuit in Baber. Consequently, hospitals in Virginia may be faced with the incongruous result that they are subject to liability for alleged violations of EMTALA in the inpatient setting when sued in state court, but are not subject to such liability if sued in federal court.

In addition, on October 7, 1992, the United States Court of Appeals for the Seventh Circuit reversed the holding in Johnson v. University of Chicago Hospitals, 774 F. Supp. 510 N.D. Ill. 1991), rev'd, ___ F.2d ___, 1992 WL 259404 (7th Cir. Oct. 7, 1992), a case cited by the Hospital in its petition at 24 and by the American Hospital Association in its amicus brief in support of the petition at 6, in which the district court had dismissed EMTALA claims against the defendant hospital ("UCH") on the ground that the plaintiff had not met the Act's

threshold requirement of alleging presentment to the hospital's emergency department. The Seventh Circuit held that EMTALA applies where paramedics responding to an emergency call at the infant patient's home communicated by telemetry with a nurse at UCH, which served as the resource facility for the South Chicago Mobile Intensive Care System, and were advised to transport the patient to another hospital because UCH had declared a partial bypass due to the lack of pediatric intensive care beds outside of its emergency room. 1992 WL 259404, *1, *4.

There remains a conflict among the courts whether presentment to a hospital's emergency room is a requirement for triggering the duties and liabilities prescribed by EMTALA. See, e.g., Daniels v. Wills Eye

Hosp., No. Civ. A. 91-2309, 1992 WL 103009 (E.D. Pa. May 7, 1992); but see, e.g., Helton v. Phelps County Regional Medical Center, 794 F. Supp. 332, 333 (E.D. Mo. 1992) (citing approvingly Smith v. Richmond Memorial Hospital, 243 Va. 445, 416 S.E.2d 689 (1992)). In Richmond Memorial Hospital, the Supreme Court of Virginia distinguished the district court's holding in University of Chicago Hospitals on the ground that the patient was not taken to the emergency room of UCH, "nor was she ever even present in the hospital." Petition for Certiorari, A-22 through A-23. The Seventh Circuit's reversal in University of Chicago Hospitals, allowing an EMTALA action to proceed against a hospital where the patient never came to the hospital at all, let alone to its emergency room as required by the Act, serves to further

point out the confusion which exists among the courts regarding the proper interpretation of the Act, the disparate impact on hospitals throughout the country and the need for this Court to grant the Hospital's petition for certiorari in order to establish for all courts, state and federal, that the threshold requirement for an EMTALA claim is presentment to the emergency department of a Medicare participating hospital and that subsections (b) and (c) of the Act are not to be read out of context to create liability in an inpatient treatment setting or after initial stabilization when no such liability was created by Congress.

CONCLUSION

For the reasons stated above and in the Hospital's petition for certiorari, the petition should be granted.

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